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HEALTH CARE FOR THE ELDERLY: WHAT'S IN THE FUTURE FOR LONG-TERM CARE?

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-SEVENTH CONGRESS

SECOND SESSION

BISMARCK, N. DAK.

APRIL 6, 1982

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HEALTH CARE FOR THE ELDERLY: WHAT'S IN THE FUTURE FOR LONG-TERM CARE?

TUESDAY, APRIL 6, 1982

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Bismarck, N. Dak.

The committee met, pursuant to notice, at 1:30 p.m., in the Burleigh County Senior Citizens Center, Bismarck, N. Dak., Hon. Quentin N. Burdick, presiding.

Also present: Ann Humphrey, legislative assistant to Senator Burdick; and Kathleen M. Deignan, minority professional staff member.

OPENING STATEMENT BY SENATOR QUENTIN N. BURDICK, PRESIDING

Senator BURDICK. The committee will be in order.

We are holding this hearing today to talk about how long-term care can develop in the future. What services people need, what services they are likely to get, and how the Government can encourage the development of those services people need most.

The subject of this hearing, long-term care for the elderly, has been called one of the most pressing problems which will face this country in the next decade.

Our elderly population is growing. Today, those over the age of 65 number 24 million. Within 15 years, this number will be 32 million. The population age 85 and over, those who are most likely to need nursing homes or other forms of long-term care, will triple within one generation.

The cost of nursing home care is increasing dramatically. In 1975, the total nursing home bill in this country was less than $10 billion. Today, the bill is $24 billion. And by 1990, it will be $76 billion unless some changes are made in the way we structure our long-term care system.

I know that the high cost of nursing home care is not news to anyone here. Almost 50 percent of this bill is paid for by patients and their families, not by the Government.

The cost of nursing home care and growth of the elderly population are just two reasons we hear so much about new programs to provide services to the elderly in their own homes and in the community. We all know that we need to find more cost-effective ways to meet long-term care needs.

But there is another reason. And that is that older Americans want, above anything else, to remain independent and in their own homes for as long as possible. We hear over and over again from older Americans that they prefer home care even to the very best nursing home care.

Many of us on the Senate Committee on Aging are working to support home and community long-term care programs. I am sponsoring a bill to expand the medicare home health program to include homemaker and home health aide services, and another bill to include a full program of hospice care as a medicare benefit.

We also have introduced a bill to remove the requirement that an elderly person be hospitalized before becoming eligible for nursing home care under medicare.

We are now working on bills to authorize a tax credit to help families who want to care for an elderly relative in their own home, and to remove barriers in other laws which discourage this, such as the law we have now which reduces the supplemental security income of an elderly person if he or she is living with someone else.

And we recently passed a bill to reauthorize the Older Americans Act for 3 years. This is one of the very few new authorizations to come out of Congress last year.

But no matter how much we can improve home health care and other community services, a level of care which can only be provided in a nursing home will always be needed. We all have to work as hard as we can to make sure that nursing homes have every opportunity to provide the best care possible.

Some of you may have heard that there was a lot of controversy recently in Washington over new rules that the administration was going to propose for nursing homes. There was a fear that important safeguards for patient health and safety and dignity were going to be removed.

I am all for reducing unnecessary regulations and paperwork, but we cannot compromise on health and safety. I protested, along with the entire Committee on Aging, and the Secretary announced a few days ago that the changes would not be made.

I am also concerned about proposals in Washington to make large cuts in the Federal budget which I think would affect nursing homes. Not only do we have to safeguard the quality of nursing home care, but we will need additional nursing home beds before too long.

I have asked some of our witnesses on the third panel to address these budget cuts because I am anxious to find out just what effect they would have here in North Dakota if they are passed by Congress.

I would like to explain a little bit about how this hearing will be conducted. I hope all of you have seen our witness list. We will take testimony from three panels of witnesses, and I will probably have some questions for them after their testimony.

Since this is an official hearing of the U.S. Senate, we have a court reporter here who will be recording our statements.

After we have gone through these three panels, we will have time for anyone else who is here who wants to make a brief statement.

Since this hearing is on long-term care, I will ask you to limit your comments to the subject. If you don't have a chance to make your statement, we will take it in written form, and it will be made a part of the hearing record. There are sheets of paper in the back of the room for you to use for that purpose. You can either give them to the staff here today or mail them to me.

Before we start the hearing, I would like to thank Leo Fettig, director of the senior citizens center, and the staff, for being our hosts. I would like to thank the staff of the North Dakota Aging Services Office for helping us prepare for the hearing.

I would like to point out that our staff member, Ann Humphrey, from my staff in Washington, and Kathy Deignan from the Committee on Aging, are here with you today.

Before we hear from the first panel, I am going to insert into the record the statement of Senator Mark Andrews, who is unable to be with us today.

[The statement of Senator Andrews follows:]

STATEMENT OF SENATOR MARK ANDREWS

Mr. Chairman, I appreciate the opportunity to submit a statement at this field hearing on long-term health care for the elderly.

Only a previous commitment to be in Fargo later this afternoon prevents me from presenting testimony in person.

The appropriateness of this hearing, and I commend Senator Burdick for conducting it, is best evidenced by the fact that the number of elderly Americans has been growing rapidly and this expansion is expected to continue for many years.

In North Dakota, 17 percent of the population is over the age of 65. Nationally, each day there is an increase of 1,600 persons over 65. This increase in the number of people over 65 can be attributed to the excellent health care which this country has to offer.

These changes in population of the elderly indicate a definite need for expanded long-term health care services.

There are currently two bills of great interest to me that deal with long-term care. I am a cosponsor of the Community Home Health Services Act which will encourage the coverage of home health programs and provides expanded coverage of home health services under the medicare and medicaid programs.

As public funds become scarce and the need for long-term care grows, every possible effort should be made to encourage alternative arrangements, such as among family and friends, church groups, and community-based organizations. The Community Health Services Act provides the incentive for this alternative arrangement.

Mr. Chairman, another long-term health bill would amend the Social Security Act to provide for coverage of hospice care under the medicare program. I am a strong supporter of the hospice program and feel it will be very helpful, as well as economical. Not only does it reduce the cost of hospital care for the elderly and terminally ill, but it helps make parts of our social security system stronger financially. This legislation alone could save from $13 million to as much as $135 million per year in hospital costs.

The future of health care for the elderly is of great concern to me. The elderly of America have brought us where we are today and we owe them a great deal. By expanding long-term health care services we can help improve the quality of life for the elderly of this country.

I want to assure the chairman, and other members of this committee, that I am willing to assist in any way in efforts to insure proper expansion of health care for the elderly.

Again, thank you for this chance to air my views on the subject of long-term health care for the elderly.

Senator BURDICK. So now let us start with panel No. 1.

I have just been advised that the first panel will consist of three, not four people. And they all have been very gracious and have agreed to tell us something about their personal experiences.

So the first witness I shall call upon will be Mildred Monke, from Dickinson.

Miss Monke is caring for her 90-year-old mother at home. She is a member of the Governor's Council on Aging, president of the County Council on Aging, and on the steering committee of the Silver-Haired Legislature.

Miss Monke.

STATEMENT OF MILDRED MONKE, DICKINSON, N. DAK., MEMBER, GOVERNOR'S COUNCIL ON AGING; PRESIDENT, COUNTY COUNCIL ON AGING; AND MEMBER OF THE STEERING COMMITTEE, SILVER-HAIRED LEGISLATURE

Miss MONKE. Thank you. The problems of the aging or the elderly branch out into many areas, but the one to which we are speaking today, in my estimation, is basic. Where and under what circumstances the older person lives, measures the mental and physical well-being of that person.

I live with my 90-year-old mother, as Senator Burdick has stated. I am 2 months away from being 70 years old. My father died in 1964, but we still own and maintain our own home in Dickinson.

Mother and I share responsibilities in keeping our home. Her eyesight is giving her problems now, but she still is in charge of preparing our meals, doing the laundry, and some of the light cleaning. Up until a few months ago, she worked with and took care of all household expenses.

My responsibilities center on running all errands, heavy housework, outside work, repairs, the automobiles, and many other chores associated with living in our own home. This arrangement has worked beautifully, contributing to our sense of security, and good mental and physical health.

However, the time has now come when a slight disability on my part sends us into near panic. What alternatives in living situations are available to us?

We have good friends and neighbors. I have a cousin and his wife who show us utmost care and concern, but you and I know that friends, neighbors, and relatives too heavily leaned upon can disappear, and then that precious moral support is also gone.

We would, for the present, prefer to remain in our area of North Dakota, but our only alternative living arrangement would be one of the two nursing homes in Dickinson. Unless we are flat on our backs with illness or disability, we would find this arrangement quite unacceptable.

What we would like to have available would be home and health care services such as nursing care supervision, cleaning, yard maintenance, shopping service, transportation, et cetera. Not free service but reliable service. In other words, just a little help to carry on in our little spot here on Earth.

Some of the services mentioned are available in our area but are so limited by lack of funds that one would hesitate asking for them. This is our situation. Basically, it can be multiplied over and over by older people on all financial levels. For those whose financial situation is very limited, the feeling of insecurity must be devastating.

I asked a friend the other day what he would do in our situation. His quick, and I am sure unthinking, reply was "Call Job Service." I then pointed out to him how unwise it would be for us to call in a total stranger, allowing that person to become familiar with our home, and with us, when the energy boom climate in our area is drawing on all sorts of people desperate for work. He agreed.

What we need in our area are funds, medicare, medicaid, other State and Federal moneys, private and benevolent funds channeled, not into more skilled nursing homes at this present time, but into retirement complexes with minimum services, basic care facilities attuned to presenting the maximum independence for the residents. Any arrangement which provides a chance for older people to maintain their independence and dignity, without first using up all their savings and making them wards of the State, should be our goal.

This kind of program sounds costly, but in this time of inflation there is a need to come to grips with the greatest value out of every dollar. Fortunately, nationwide and in our State, alternative living and care facilities are being built and we hear of good thing happening. This hearing is an encouragement to me and to others in our area that we are working to this end.

So often we do a lot of planning and talking but action is a long way down the road. Basic to the problem, of course, is money, and I guess that will always remain a problem. But something needs to be done to help older people maintain their independence and well-being when age takes its toll on physical strength.

If our Nation can send the Space Shuttle into space and bring it back as a glider, surely there must be people available who can use their wisdom and talent on behalf of older people. Action that will affect all people at one time or other in their lives.

Thank you.

Senator BURDICK. Thank you, Miss Monke.

Our next witness will be Mrs. Ernest Davis of Bismarck. She went through a very trying period with her husband, who was in a nursing home and has since died. I think she can tell us what it is like to have to make that decision, to put someone in a nursing home.

Mrs. Davis.

STATEMENT OF MRS. ERNEST A. DAVIS, BISMARCK, N. DAK.

Mrs. DAVIS. When I first put my husband in a nursing home, it was really a shock to me. It is like putting him in prison and waiting for him to die. This is the way it appeared to me. And the hardship and financial burden it caused me was enormous. It took everything we had, and there was nothing left for me. I had to go out and babysit. And the small amount I received in rent for my apartment was not enough for me to pay my bills.

The financial strain is so great. The last month I had my husband in the nursing home, the bill was $1.440; and that doesn't include drugs. And another thing, the nursing homes have a rule—they have their own druggist, and you have to get the prescription through that druggist. I have checked around in places in several various drug stores, they are twice the price usually of your own druggist, which I think is uncalled for.

Many people are in the nursing home that I don't believe they even belong there. Anybody that can walk and help themselves, and go to the bathroom, and dress themselves, doesn't belong in a nursing home.

Fear of retaliation. You go in there and they tell you what you can do and ask you how your patient likes the food, and what kind of a diet he is on, and what he can have, and what he can't have. If you do complain, they get real nasty with you. I have seen times when people didn't seem to like something, not my husband, another resident. And they say, "Well, if you don't like it you can go to your room," instead of deciding to go and get them something else, which I think is uncalled for.

And there is no communication among the administration, the dietitian, or the staff that is working on the floor.

So many times I think they have inexperienced help. They bring young help in. They have no experience of handling these people who are invalids, and I think they need special care. There should be somebody that knows how to handle these people.

I have seen their skin torn, and it was all through carelessness. Also broken fingers and broken hips. Then people are not supposed to complain.

When I did complain, I have been called to the office and harassed by different individuals. But I stood my ground. They even stooped so low to say, "You must feel very deeply about your husband." I said, "You bet I do. And I feel very deeply about each and every one of these people in here."

They said, "I don't care what you think or what you say."

I said, "You are going to have me to fight as long as I live." And I said, "I hope I live a lot longer than you do." Well, that ended it and then they kind of left me alone for a while.

I even had one administrator call me at night, and the nursing director. I said, "There is good and bad, don't get me wrong." I said. "I don't condemn the good. Some do care, but those who don't, make it bad for everyone."

Once a nursing director told the administrator I was complaining. The administrator called me at midnight and said he was going to bring my husband over and dump him on the doorstep.

And I had an everlasting fight with the diet. They never wanted to give him his diet. My husband was sick, he couldn't eat everything. Anything that disagreed with him, it would just come back up, if you don't mind me saying so. They just didn't seem to want to give him his diet.

When I would ask a question about something, they said, "You don't need to know. What are you talking about? You are not a dietitian; you are not a nurse." I said, "I followed a doctor's diet at home and did not have any problem. I don't have to be."

The only thing they wanted me to do was pay my bill and keep my mouth shut. I was not about to. I have tried many, many ways, but you can't get the people to back you up. They are afraid they are going to have to take their loved ones home and take care of them.

Thank you.

Senator **Burdick**. Thank you.

Our next witness is Walter Domrese, from Williston, past chairman of the Governor's council on aging, now president of the State AARP. He is also a chairman of the steering committee for the Silver-Haired Legislature. He has been involved in the long-term care issue for some time.

Mr. Domrese.

STATEMENT OF WALTER J. DOMRESE, WILLISTON, N. DAK., PRESIDENT, NORTH DAKOTA CHAPTER, AMERICAN ASSOCIATION OF RETIRED PERSONS; FORMER CHAIRMAN, GOVERNOR'S CONFERENCE ON AGING; CHAIRMAN, STEERING COMMITTEE, SILVER-HAIRED LEGISLATURE

Mr. DOMRESE. Can you hear me clearly? I have been a member of the State health coordinating council for 2 years. I have been a member of the Western Dakota Health Systems Agency since its inception, which now amounts to 5 years and 8 or 9 months, and which will very suddenly be put out of business by the providers, who have dominated that board all this time. Now, I am going to get into my testimony.

Our problem in North Dakota is that medical care delivery—and it should really be called sickness care—not health care. People have been duped into thinking it is health care and it is not—it is "high tech," short term, and institution oriented.

We have more nursing homes than any other State in the Union, save six. While the national average of elderly in nursing homes is 5 percent of the population, in the State of North Dakota, we find that we have anywhere from 5 to 14 percent, depending on the area of the State.

We have experts of international repute that declare that anywhere from 40 to 75 percent of all people in nursing homes do not belong there. If this is true, and I am sure it is, we are oversupplied with long-term care institutions.

In western North Dakota alone, we have a surplus of anywhere from 400 to 1,400 hospital beds, depending on who is telling the story. If you are a provider, there are only 400. If you are consumer who pays the bill, there are 1,400. And now we have a program to make long-term beds even more plentiful through the swing-bed concept. Not only that, some nursing homes in western North Dakota, have received permission to reclassify their beds to the highest level of care because that is where the money is.

Some nursing home operators claim that all their residents are screened for admission and level of care. I was on a so-called screening team for several years, and all we ever talked about was money.

The nursing home administrator, fighting to get that person in the highest, most expensive-care category, and the screening team member representing the public and the welfare board, did what he could to get the proper care for the patient, all that he needed, but not more.

I am going to give you a real example of how this works.

Angie Bousilman lives in Williston, and Senator Burdick knows her, this woman was born a spastic. She went into a nursing home, and after she was there a week, she was put in skilled nursing care.

I went up there a couple of days later and here was Angie laying in a bed. She said, "Walter, I have got to get out of here. These people are going to kill me."

And I said, "Angie, where do you want to go?"

She said, "Anyplace but here."

I then got her a room at Mrs. Bender's and later she went to the Plainsman Hotel. And now she has an apartment of her own.

This happened 12 years ago. And this woman, all during those 12 years has been able to take care of herself. And these people put her in a skilled nursing bed.

The way I understand long-term care is that it starts the minute elders can no longer completely take care of themselves and need some assistance to live properly, meals brought in, housekeeping, a weekly visit by a nurse. This sort of thing is not widely available in North Dakota, because it has never been encouraged. I want you to listen to this now. It is true. The last biennium, the one before this, the indigent in nursing homes of North Dakota took over $50 million of taxpayers' money. Do you know what they are taking this biennium? They are taking $30 million more.

We tried to get $1 million from the State legislature to encourage services that would keep elders in their own homes as long as possible, and do you know that it was defeated? I am going to ask you a question and you think about this: Do you suppose the fact that the House Appropriations Committee was under the chairmanship of the secretary of the North Dakota Medical Association—if this isn't conflict of interest, I have never heard of it.

Many of our elders prefer to live in rural areas where they have always lived. Many of these are medically underserved. In North Dakota, the "medics" have arranged it so that a nurse practitioner must be under the direct, in-house supervision of a physician. This means the old must drive miles and miles for medical attention that could be had close at home, because it is a well-known fact that doctors will not live in sparsely settled communities.

Freestanding nurse practitioners work well in many States and North Dakota is one that needs them.

We have a fine man working at the University of North Dakota. His name is Dr. Theodore Reiff. He has started something that is badly needed. He is the director of the UND Medical School Department of Geriatrics and Gerontology. He has begun to train doctors who will actually pay attention to the old.

Now, we had the president of the University of North Dakota down in Fargo when I was chairman of the Governor's Commission on Aging. He said, "Walter, what do you need?" I said, "We need doctors that will pay attention and look at the elderly." We don't need people who are in that position to attribute all the problems of the elderly to old age. People do not die from old age. They die from specific causes.

We need medical schools to produce doctors who are prepared and willing to practice geriatric medicine. All people are people, they are not crocks, they are not spooks, they are not zombies, as Dr. Robert Butler, who wrote the book "Growing Old in America: Why Survive?," had his instructors in medical school teach him.

Our State nursing home laws appear to have been written by nursing home operators for the benefit and protection of nursing home operators. And later in the testimony, if we have a nursing home operator sitting up here telling you that is wrong, I will tell you that I have read every nursing home law in the State and what I am telling you is true.

There is no way for the public to evaluate the quality of care of a nursing home if there is abuse, or stealing, or some other nefarious circumstance called to the attention of the health department. That information is confidential. It is not any of your business. You are paying the bills, but you can't find out what is going on.

Now most of our nursing homes are church-related. That doesn't necessarily guarantee good care, but it wasn't too long ago that all, except 12 percent of the nursing homes in the State were church-related. Now we find that that 18 percent are for profit, all not church-related. And recently I learned that a very big corporation from California has bought three more nursing homes in the State that they are going to be run for profit.

Patients in nursing homes do not even have a bill of rights in the State of North Dakota. And if you don't believe it, recall the testimony of the lady who spoke before me. Also, nursing home boards can have members who have a conflict of interest.

I recommend that you get a copy of a book entitled "Tender Loving Greed," by Mary Adelaide Mendelson of Cleveland, Ohio. My sister knows this woman, and is her neighbor. This woman knows what she is talking about.

For-profit institutions are not necessarily bad but as the church-related homes are taken over by these efficient for-profit conglomerates, we will be in a real danger if we don't have good enforced laws on the books. And you can be sure that almost every nursing home in the State will fight tooth and nail to prevent any changes in nursing home laws because the present laws are so beneficial to them.

We need a continuum of care for the elderly of North Dakota, something we do not have at present. This includes home health care, home services, and everything that would enable an elder to function independently as long as possible.

This may surprise you, we need a health department that is on the side of the consumer and the old people. At this point, the health department is not on the side of the consumer and the older person. It works hand in glove with the providers, when the proper role of the department should be to protect the consumer of sickness care and long-term care.

We must start to call the health care industry by its true name, the sickness care industry. "Health care" is doublespeak of the worst kind. All doctors and hospitals and nursing homes know there is no money in health. Money is in sickness, and I think one of the problems of the U.S. Senate Special Committee on Aging is to find a way to make health profitable.

Medical and hospital costs are so excessive that many old cannot afford the care they should have, so they stay away. Medical costs go up, medical care benefits go down, the old are burdened with drug and medical costs.

I have not seen one doctor or one hospital in the entire State of North Dakota sacrificing anything in any way thus far. They get everything they ask for, and we pay the bill.

Five CAT scanners are four more than we need for western North Dakota, and now the hospital in Dickinson, N. Dak., is looking at the new super job which is going to cost between $1 million and $1,500,000. It is the latest thing. CAT scanners are now obsolete.

Do you know that in 1981 alone, the hospitals and nursing homes got plant and equipment in the amount of $354 for every man, woman, and child in the State of North Dakota? You are paying for this. And the hospitals, if you go to them, or the nursing home, or whatever, and complain about your bill, they have the nerve to tell you, "What are you complaining about? Your insurance pays for this." Who is paying for the insurance? It isn't them, it is you.

Now that the HSA in western North Dakota is being eliminated, and with Dr. Joan Griggs Babbott cleaning out the health care development agency, and the only reliable friend the consumer ever had, Georgio Piccagli, the way is clear for any amount of spending by hospitals and nursing homes and they are taking advantage of it.

The State health council, SHCC and HSA, will give the hospitals and nursing homes anything they want. The certificate of need process is a farce in North Dakota.

Medical care, sickness care, is a monopoly that is free of normal market forces and probably should be treated as a public utility. We need a State law to set up and control this monopoly.

We need to replace the third-party payment system with one that prevents the medical community from charging what they will with confidence that regardless of what is charged, the ever long-suffering public will pay.

And in closing, I would say that the cost and quality of care have very scant relationship to each other. You think you are going into a high class nursing home because you are paying $19,000 a year, but you are not necessarily getting the best care in the State.

You might go into a nursing home that is only charging half that and get much finer care than in a more expensive one. What is going on? They are ripping us off, and I mean the taxpayer, and the old person who enters a home—most of whom are on welfare after 2 years in a home.

Nursing homes do not have to be palaces with rates accordingly. Nursing homes have a place in long-term care but not the major role and the claim to money they now enjoy.

At least 90 percent of what doctors do is either useless or harmful. They claim to be scientific but medicine is still an art. The public has been brainwashed into thinking that they are getting more than they are.

Now, Senator Burdick, I have something to say to you.

The Senate Aging Committee has held countless hearings. I have a whole file full of them. Most of what will be said today has been said 10, 15 years ago. Why are doctors, hospitals, and nursing homes permitted to raid the public pockets with impunity? When will it stop? When will the public realize what is being done to them? God help Senator Burdick in answering those questions.

Thank you.

Senator BURDICK. Thank you very much, Mr. Domrese. Your prepared statement will be inserted into the record at this point.

[The prepared statement of Mr. Domrese follows:]

PREPARED STATEMENT OF WALTER J. DOMRESE

Mr. Chairman and committee members, my name is Walt J. Domrese. I am from Williston, N. Dak., and I am testifying as a private citizen. I am a member of the State Health Coordinating Council and of their Plan Implementation Committee. I have served as a board member of Western North Dakota Health Systems Agency since its inception 5 years and 3 months ago, under Public Law 93–641 and related laws and amendments, and on their Plan Development Committee and other related committees during that time. I am a senior citizen and a consumer of health care, a native, and almost lifelong resident of North Dakota. My interest in nursing homes evolves in part from my background and training in sociology and social work and from knowledge I have gained as a board member of the State Health Coordinating Council and the Health Systems Agency.

In 1939, a 3-story former dwelling was the only "nursing home" in Jamestown, N. Dak. I called there frequently, as most of the 25 men and women living there were on welfare. Board, room, and laundry were offered but little else. The old people sat around looking at each other with nothing to keep them occupied, but they accepted their lot with little complaint, because that was what was supposed to happen to you when you got old.

Nursing homes, as we know them today, are a new development—it is only in the past 35 years that most have been built in North Dakota, and I must say we have one of the best nursing home setups in the entire United States. In fact, only 5 percent of all people 65 and over are in nursing homes in the 50 States, but in North Dakota we find as high as 12 to 14 percent in some areas of the State.

Our own Dr. Reiff, head of the department of geriatrics and gerontology at the University of North Dakota and an international authority on aging, says flatly, that 40 percent of all people in nursing homes do not belong there, but are there only because the community provides nothing else for them. The Menninger Foundation puts the figure at 75 percent.

It has been proven that the old do better in their own homes. A person released from a hospital to a nursing home will take about twice as long to recover as one going back home. Even for the old there is no place like home.

On February 11, 1980, the Governor's Commission on Aging passed the following resolution:

"Whereas North Dakota has more nursing homes per capita than any other State in the Nation, except six, and

"Whereas the most learned and reliable geriatricians and gerontologists agree that as high as 40 percent of the inmates in said homes do not belong in them, but are there because there is no place else for them to be, and

"Whereas this committee is assured this same situation obtains in North Dakota, and possibly even more so: Now, therefore, be it

"*Resolved*, (1) That no more nursing homes, or additions thereto, be built in the State until this situation is corrected. (2) That nursing home governing bodies consist henceforth of persons who have no conflict of interest and no vested interest in said nursing homes. (3) That admissions and discharges to and from nursing homes in North Dakota be regulated by suitably composed screening committees to insure that only those who are qualified are henceforth admitted to said homes."

In Senate Resolution No. 4053 are stated a few allegations of questionable conduct by nursing homes in the conduct of their business. You have all read them. If they have any foundation in fact, and I know some of them do, it is because of the nursing home laws and regulations appear to have been written by nursing home operators for nursing home operators. Up until recently, 89 percent of our nursing homes in the State have been church-related and not for profit; but now large for-profit corporations are entering the State. For example, Mandan Villa was recently taken over by Beverly Enterprises, a Pasadena, Calif., proprietary corporation, currently operating 345 long-term care facilities in 23 States.

Beverly Enterprises bought up so many nursing homes in Florida, they were declared a monopoly, and an alteration in their operations had to be made by the State. Attached is further material on Beverly Enterprises which should prove of interest to this committee.

Proprietary operation of nursing homes is not necessarily a bad thing, but it could be and when most of the States nursing homes become proprietary, we better have some workable and reasonable nursing home laws in place or we will be in trouble.

WHAT REALLY IS A NURSING HOME?

First and foremost, it is an institution, and people who live in institutions become institutionalized. They no longer are their own people. It is also a special kind of hospital—not as complicated as a regular hospital—but it has most of the features attributed to hospitals and the operators of nursing homes learned their methods from hospitals, including attitudes toward themselves and those whom they care for. Further, nursing homes are money machines and are listed as high growth, high profit enterprises for the 1980's along with silicon chips and genetic engineering.

Also, they are part of the laissez-faire health industry. There is "wheeling and dealing" going on in the nursing home industry over which the State has little knowledge and little control.

Because nursing homes definitely are part of the health care industry and I feel obligated to present to you the following:

Pages 194 and 195, Florida and California: Page 1. "Recommendations for California Health Facilities Commission," Gordon R. Cumming. July 3, 1980. (Gordon Cumming has been involved in virtually every aspect of health care delivery and regulation over the last 41 years). He says: "I believe that failure to control health care services and cost through some method of public accountability will create the demise of the present voluntary health system. I would like to see the present system be receptive to reform and become more accountable to the public, rather than hold out against change until its own myopia destroys it."

Page 6. Einar Mohn, chairman of the California Council for Health Plan Alternatives says: "The industry is well organized to make good use of me as an economic unit, but is almost totally without organization to treat me as a patient.* * * The health industry is the last great reserve of laissez-faire economics in our society. No other industry serving a social need—housing, transportation, food—has so little compulsory responsibility to the public. You do not answer to any public agency for the prices you charge, the location of your services, or the quality of your performance. In addition, your industry is noncompetitive so that you are without market constraints. The power of physician organizations over American life is awesome. I urge you to develop institutions that can meet the challenge set forth by Congress, that health care is the basic right of every American."

Page 9. Archibald Cox, chairman of Common Cause, says: "Washington has become the forum in which special interests, business corporations, and other organized groups, contest for tax breaks, regulatory advantage, subsidies, rich Government contracts, and other advantages often with ruthlessness and deceit * * * now the central challenge is to make Government effective. We cannot continue to let dairy interests dictate agricultural policy, truckers and teamsters to dictate transportation policy, the American Medical Association to block control of hospital costs, and other interests to feather their nests at the expense of progress of all. There are no panaceas, no milleniums. We can proceed only step by step, accepting compromises, and then going back for more."

Page 20. California recommendations.

(1) Need for an independent commission to monitor the performance of health facilities in an impartial manner.

(2) Public disclosure of health facility services and costs to provide information needed by the public, the State, insurance and other prepayment organizations, and by providers in rational decisionmaking on public policy affecting service of health facilities to the public at large and to State programs.

(3) Sound comprehensive State and community-based health planning based on facts and not on special interest group desires.

(4) Budget/rate review and approval by a totally independent body of all health facilities.

(5) Strong certificate of need program which is in full compliance with Federal law, with no loopholes allowing continuation of facilities and services which can be replaced or substituted in a more appropriate and cost-effective manner.

(6) Sound and uniform systems of accounting for financial information and medical recordkeeping for patient information.

(7) Increased emphasis should be placed on nursing home disclosure. The issue of nursing home service is a sleeping grant. It is evident if funds continue to be available for care, the nursing home industry has almost unlimited expansion possibilities. The public needs to learn more about this through disclosure and special studies.

(8) There should be more accountability of health facility governance. This should include information on ownership, affiliations, contracts for management, and other services. There is some pretty "high rolling" financing of mergers, etc., currently.

(9) One of the most serious abuses of public accountability and trust by health facilities is their large and rapidly growing expenditure for political action committees, association dues, attorney fees, etc. When health institutions get more than half of their income from public tax funds, it is incongruous that much of the money is used to fight public accountability, both politically and in court.

(10) Disclosure is the prime tool to keep the facts before the public.

Page 83. In no other realm of economic life today are payments guaranteed for costs that are neither controlled by competition, nor regulated by public authority, and in which no incentive for economy can be discerned.

These recommendations are of course applicable to every State in the Union, and certainly to North Dakota.

We are interested in seeing that residents of North Dakota nursing homes continue to receive good quality care. We think our nursing home laws need revision to help insure that this be so. The old laws have served their purpose and need renewal on the basis of what we have learned about long-term care of the old in the past 40 years.

In North Dakota at the present time the frail elderly have two choices basically. Either make do the best you can at home, or enter a nursing home.

There is some home health care available in parts of the State, and if you are on welfare you can get home health aides and chore services in many counties, but for the vast majority, it is either home or nursing home with little in between.

What we are interested in developing in North Dakota is a continuum of care.

WHAT IS A CONTINUUM OF CARE?

My understanding of the term would be that a continuum of care involves the availability of a sufficient number of community services to permit an elder to live at home and independently as long as possible.

This is an article I hope the committee will read. It describes what I hope will eventually be available in North Dakota—it is New York's, "nursing home without walls" program.

Last biennium $51 million was spent in North Dakota to pay for the indigent in nursing homes in the State. This biennium that has increased about $30 million to $81 million. There was a bill in the last legislature asking for $1 million to encourage home health care and home services, but it was defeated because certain interests assured legislators that medicare takes care of this, when such was, and is not the case, except in limited special situations.

Current public policies and programs do not provide a reasonably comprehensive and coordinated range of community-based long-term care services. Instead, we have a mix of laws, policies, programs, and agencies which result in serious gaps and overlaps in available services and in client eligibility. We have very high government expenditures for medically oriented institutional care and very little for large numbers of persons who need less costly social maintenance care in their own home and community. Last year Federal expenditures for skilled and intermediate care were double that for all of the combined: SSI, title XX services, in-home care under titles XVIII and XIX of the Social Service Act, community mental health, special housing by DHUD, and Older Americans Act funding.

Families provide more care at home for the elderly than all present public and private care facilities combined.

New York has found it can provide care at home at 50 percent less than nursing home care, and 87.8 percent less than acute hospital bed care.

There are other things that can be done and many States are doing them. In a report of the Special Committee on Aging, U.S. Senate, May 1981, page 22, policy topic, "elderly as a national resource," conclusion No. 1: "The Federal Government has a responsibility to enhance the potential for usefulness of each of its citizens to assure their autonomy and control over as broad a range of individual options as possible for as long as possible."

Low-income people are considered to be at greatest risk of institutionalization.

Page 82. "New Aging Radio" (two-way "Telephone and Radio") established by assistance of Aging Commission of Ohio. Listeners are invited to write in with questions, concerns, leisure, legal matters, housing, and new lifestyles; designed to involve those who live alone. Is conversational in tone, entertaining, educational, and encourages participation of the audience.

Life Line, Fulton County, N.Y. An emergency alarm system now being used by vulnerable elderly and handicapped people living independently. Based on 24-hour emergency station, and small box that plugs into the phone and dials the emergency station. with the press of a single button. If the called does not respond—a predetermined list of nearby helpers is called to give immediate response. This cooperative community effort has encouraged service providers and other groups, such as churches, service organizations, and public agencies to identify the most vulnerable residents of the community and increase their access to community and emergency services.

In Florida, a "companion service" provides a personal in-home emergency service which senses when a person needs assistance and automatically summons help via trained personnel. It is based on the installation of a private phone line and strategically placed sensors in the home. An assist button, which can be carried, allows the person to contact the communication center. Some 800 individuals, 85 percent of whom are elderly, are being served in Pinellas County, Fla., and the system plans to expand.

Page 185. Monroe County, N.Y., has an ongoing community care demonstration that has been in action 24 months. Among its objectives are: (1) To provide long-term care services which are appropriately cost-effective, and acceptable to the clients; (2) to reduce the number of county residents who are in acute hospitals and long-term care institutions.

Preliminary data shows that home care costs for long-term care patients are from 30 to 50 percent of the county's comparable institutional rate.

Page 188. Oregon, FIG waiver continuum of care project for the elderly, five counties for 3 years, 1,002 individuals are being cared for. Counties have shown consistent reductions in expenditures of medicaid funds for nursing home care.

Page 189. Connecticut, Triage. Based on a single entry access point to the health delivery system for the elderly. The project is designed to build an appropriate interface between client and multiple service agencies whereby care is organized around the client and the available resources. It has been operating since 1974. Data from the project is presently being analyzed, but it is reported that in 1978, the average cost per participant per day was $12.63, and this covered many ancillary and supportive services not traditionally covered by medicare.

IN SUMMARY

We need a continuum of care for all of North Dakota's old and handicapped people.

We need new nursing home laws to replace the present ineffective outmoded provider protective laws and regulations. These should, at the minimum, provide rules for:

(1) A patient's bill of rights.
(2) Liability of facilities. Remedies and penalties.
(3) Management of residents funds and property.
(4) A contract for care.
(5) A residents advisory council.
(6) Discharge and transfer.
(7) Procedure for closure of facility.
(8) Public disclosure of certain information.
(9) Creation of a long-term care facilities advisory board.
(10) Minimum standards.
(11) Inspection and reports.
(12) Licensure.
(13) Statement of ownership.
(14) Transfer of ownership.
(15) Financial statement.

(16) Prohibition of receipt or payment of certain fees (kickbacks).
(17) Monitors and receiverships.
(18) Conflict of interest.

I thank the chairman of the committee for this opportunity to testify, and on behalf of the elderly of North Dakota, as a staunch and outspoken advocate, I hope this effort will in some small measure bring a bit more quality and dignity, and more independent years to some of them.

Thank you.

Senator BURDICK. I have some questions, Mr. Domrese. Do you want to come back to the panel? I have some questions for all three of you here. You made yourself emphatically clear.

Mr. DOMRESE. I hope so.

Senator BURDICK. I mentioned that we were working on a bill to provide an income tax credit for those who are caring for the elderly families in their home.

My question is: Will this provide any help, and what kind of expenses do you think ought to be covered? Anyone on the panel.

Mrs. DAVIS. Usually, the elderly who are on pension, most of them don't have any savings really to speak of that they do pay income tax on. So actually they are not burdened with income tax. Anyway, I wasn't at the time my husband was in there. I mean, he was on a pension.

Senator BURDICK. I was thinking in terms of a son or daughter who had an income and they were talking care of—

Mrs. DAVIS. Well, that is different.

Senator BURDICK. Does that have any merit?

Mrs. DAVIS. I would think it would.

Senator BURDICK. When we talk about long-term care we are talking about nursing homes, home health, homemaker and chore services, meals-on-wheels, senior center services. What kind of services are least available? Which are the hardest to find when they are needed?

Mrs. DAVIS. Usually to get somebody to come into the home and help you. I mean, this has been the hardest and I have tried it. The hours are too flexible, and nobody seems to want to work that way, anybody that needs a steady job. I think it would be appropriate to organize a group who are willing different days to go in and help and keep some of these people out of the nursing home. And I think the patient would be much happier and more content. I think this, we as senior citizens ourselves, can do.

As I see it, no one is going to be exempt from getting sick or anything. It doesn't make any difference who you are, not one of us is exempt. And I think we need to prepare for that, and I think that kind of a program would be well spoken for.

Miss MONKE. I would like to say, Senator Burdick, that the greatest problem in our area is limited or lack of necessary services.

We have the senior congregate meals program; the meals-on-wheels program is very limited. Health maintenance and in-home health care services are very limited. This is the problem—these programs need to be expanded. Again, dollars are involved. What we do not have are chore services; for instance, yard care.

When the person I spoke with said, "Call Job Service if you want someone to mow your lawn," I agreed. We probably should do that and get a man to come help us. But with crime on the upswing, we are afraid.

We had two or three deaths in our area of Dickinson not long ago. We feel this happened because they became too well acquainted with the people involved. We and other older people do not want that. We do not want to have people we do not know, and can't depend upon, entering our homes to do odd jobs. That is one reason why we need programs providing reliable services to call upon. These services should not be free—probably subsidized for the poor—but for those who can afford it, payment for such services should be made.

Senator **Burdick**. I am sponsoring a bill to make homemaker services an option in the medicare program. But I think it is going to be hard to get it passed because so many people are afraid of what it might cost.

What do you think about doing something like this on the Federal level?

Mr. **Domrese**. At the present time we have the homemaker services for people who are on welfare but they are not generally available for the ordinary citizen in the counties. They don't have enough personnel. So my point, the reason I asked for the microphone, is that what we need is a people-centered, people-oriented approach in caring for the elderly, and for in-home long-term care, and not a money- and an institution-oriented setup as we have now.

If we can change our priorities and put the older people first instead of money, and if we can combat the tremendous, unbelievably powerful lobby that the medical group has in Washington and in the State of North Dakota, we might be able to accomplish that.

But the general public will not believe that doctors, nursing home administrators, and hospital administrators would do that to them. Wake up, don't be so naive. Money is the name of the game now—but it should be people. You are people and you should be treated as people. And the dollar sign should not govern in this instance; this is more than a business.

Senator **Burdick**. I am told that the average cost of a nursing home in this country is about $16,000 a year.

Mrs. **Davis**. Plus extras.

Senator **Burdick**. What do you think would happen to you if your mother-in-law, or mother, or relative had to enter a nursing home? This is a very personal question.

How many people can afford that and how long?

Mr. **Domrese**. I would like to say that in the days before Henry VIII, the church had a law that said, when a man died, his property would go to the church; that is, his house and his land, and his cattle; and his wife and children would go out in the street.

As a result, in England, at one time, as high as 80 to 85 percent of all land and cattle and property was owned by the church. Then Henry VIII came along and he changed that. Now we have the same situation prevailing here that was prevalent then. One is catastrophic medical illness. The other one is entering a nursing home.

The average person in the United States that enters a nursing home is broke in 2 years or sooner. There is no finer way to get stripped of a lifetime of savings and earnings than to fall into either one of those two pits.

Senator **Burdick**. I think you will recognize there may be some unusual cases that cannot be handled at home and it may be necessary to have nursing home care.

What do you say about that?

Mrs. **Davis**. May I speak on that?

Senator **Burdick**. Surely.

Mrs. **Davis**. Some people have no alternative. And you have people who have no one, no relative or anything; and they get up in years, and they are sick and need medical attention. I think nursing homes are fine, but I urge them to have a friend, or if you have a relative that has to go into a nursing home, make sure you go there just as often as you can, and don't have a regularly scheduled interval. Go into the room, check them out, lift up the sheets once in a while. See how it is kept, if it is kept clean, or if he has any bed sores, or anything like that, or if he has been hurt.

A lot of times patients get hurt and nobody knows what it is all about, how it happened. I think that is uncalled for. Those things are supposed to be recorded on the medical records, and I have experienced that with my husband. So, therefore, I urge all you people, if you do have to take someone to the nursing home, please check on them as often as you can, no matter how it inconveniences you. Don't look at inconvenience—look at your loved one.

Thank you.

Miss **Monke**. I would like to say that my mother and I could well afford to go to a nursing home but we have considered insurance. But then again we felt that this probably would not be wise either, because I doubt whether my mother would live very long if she were taken out of her home.

Senator **Burdick**. Well, this concept of home care is growing by leaps and bounds. I know that in my hearings in Grand Forks that the sentiment was just about the same as expressed here, that it is more desirable, that it is less costly to have people at home and near their loved ones. And I think the home picture looks better.

Now we are going to have a meeting of the Silver-Haired Legislature coming up pretty soon.

Do you think this question of home care will be discussed?

Miss **Monke**. We hope so.

Senator **Burdick**. And approved?

Mrs. **Davis**. We hope so.

Miss **Monke**. I think it is No. 1. As far as I have heard, in asking around, one of the top priorities is home care in whatever form that would take—whether chore services, nursing care services, or nursing health maintenance kind of care. I am sure it is going to be discussed and I hope eventually a bill is passed in the State legislature.

Mrs. **Davis**. The best thing is we all hope that none of you have to go to the nursing homes and you keep going the way you are.

Senator **Burdick**. I want to thank the panel. You may be subject to questions yet from the floor before the meeting is over. You may be subject to some questions in writing, so keep yourselves available.

Some of the people who have been working the hardest on these problems are with us today, and I would like to turn to our second panel.

Larry Brewster, who is the administrator of the State aging services program can tell us something about the plans of the department to help meet these needs. Mr. Brewster has with him Rodger Wetzel, who is director of the new demonstration program on medicaid optional services here in Burleigh County. He can tell us about that program.

We invited Dale Moug, director of the department of human services, to be with us today. But we were too late and he already has made another commitment. He has prepared a statement for the committee which will be made a part of the record.[1]

So many long-time care issues are involved in the medicaid program; however, we thought it would be a good idea to have someone else here.

I understand that Richard Myatt, who is director of the North Dakota medical assistance program will be here. I don't think he is here yet, but we will proceed with the two witnesses we have before us.

You may proceed in any manner you wish.

STATEMENT OF LARRY BREWSTER, BISMARCK, N. DAK., ADMINISTRATOR, AGING SERVICES PROGRAM, STATE OF NORTH DAKOTA

Mr. Brewster. Thank you, Senator Burdick.

The remarks I am going to make today will focus on what I call a model of health services in senior centers.

One of the major initiatives of the Older Americans Act is for States to develop multipurpose centers which provide a wide array of services to older citizens and can be looked upon as a focal point for services to the elderly at the community level.

Services provided through multipurpose senior centers include congregate and home-delivered meals, transportation, chore services, recreational and socialization opportunities, and health services, to mention a few.

Health services, which is the topic of our discussion today, is one of the priority services provided through senior centers. Examples of health services provided through the multipurpose senior centers include blood pressure checks, diabetes detection, hearing tests, hemaglobin tests, foot care, weight control, glucose tolerance tests, dental checks, and home visits to the homebound elderly and ill.

Health services through senior centers have several desirable features that we need to consider in developing policy for health care services to the elderly.

First, they are low cost; second, they are highly accepted by the elderly population; third, in conjunction with outreach and transportation services, health services through senior centers are highly accessible to seniors; fourth, services through senior centers are available to reach a wide segment of the older population; and, fifth, the focus of health services in senior centers tends to be prevention focused.

I will address briefly each of these major desirable features.

First, cost. The cost of health screening in senior centers within North Dakota varies from $2.26 per health screening to slightly over $17. The variance in the cost of delivering the service is dependent upon, first, whether it is an urban or a rural area in which the service is provided.

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[1] See page 27.

Second, the amount of volunteer effort that is included in the delivery of the health screening activity.

And third, the type of health screening provided.

The second desirable feature is prevention. The early detection of health problems of the elderly is extremely critical in the maintenance of health. I would like to point out two examples of the value of the provision of health screening activities in senior centers as it related to prevention.

We have a health screening project in central North Dakota that last year screened 396 older persons for hearing. Of the older persons that went through this screening process, 24 percent were referred for hearing aid evaluation; 15 percent of the older persons were referred to doctors for medical treatment which, in some cases, involved surgery.

A second senior center provided glaucoma tests. At this center, 60 screenings took place and, of those 60 screenings, there were 3 positive tests for glaucoma. Fortunately, the glaucoma was detected early, medical intervention was obtained, and the glaucoma conditions were stabilized.

Another desirable feature of health services through senior centers is the opportunity to involve medical providers in the provision of medical care on a volunteer basis. In several of our senior centers throughout the State, medical practitioners donate their time to the senior centers to provide health screening activities.

One of the better examples of this is here at the Burleigh County Senior Citizens Center where a physician, a podiatrist, dentists, and nursing students from both Mary College and Bismarck Hospital donate their time to provide health screening.

The reasons for the high acceptance of health care services through senior centers includes, first of all, the low cost of the services to the elderly; second, the amount of time and attention that is given to answering the health concerns of the elder person. We know from studies that approximately 11 minutes are spent by doctors during each appointment with an older person. At senior centers, the older people are given an opportunity to ask questions about any medical concerns that they have.

Third, is promptness in delivery. Seniors at the center do not have to wait 1, 2, and sometimes up to 3 hours to see a doctor, as may happen in a doctor's office.

And finally, the fourth is convenience. It is very convenient for an older person to come to a senior center, participate in the nutrition program, other recreational and socialization activities, and also receive health screening.

Senior centers facilitate access to health services through the other services that are provided.

Two of the most frequently provided services include outreach, in which the center moves out into the community and locates seniors that are in need of services, encourages them to involve themselves in the services, not only at the senior center but other community resources and provide followup in referrals made to the medical providers. The second service is transportation. Through transportation, access to medical services in the community can be enhanced.

Meeting the health care needs of the older person is a very complex process. The provision of health services through senior centers is just one model that can contribute to a more effective and efficient service delivery system. It can prolong the older individual's stay at home and postpone institutionalization.

The administration's proposal to cut back funds for services under the Older Americans Act may severely curtail the provisions of health services through senior centers in the future. The consequence of this may be an increased need for alternative health care, accompanied by increased demand on already scarce public resources.

Thank you.

Senator BURDICK. Thank you very much, Mr. Brewster. Your prepared statement will be inserted into the record at this point.

[The prepared statement of Mr. Brewster follows:]

PREPARED STATEMENT OF LARRY BREWSTER

The overwhelming majority of the approximately 110,000 citizens of North Dakota, age 60 and over, are vitally concerned about the impact actual and proposed Federal funding cutbacks of human service programs will have on their future well-being. These programs include social security, medicare and medicaid, food stamps, low-income housing, low-energy assistance, social services, and programs and services funded under the Older Americans Act.

The cumulative effects of Federal funding reductions in these programs will profoundly influence the capacity of many older people to maintain their independence and avoid premature institutionalization. As available resources continue to shrink, we will face greater challenges in finding more effective and efficient ways to meet the human service needs of our growing population of older persons.

The human service needs of older persons cross a broad spectrum, from social and recreational opportunities, to in-home services, to health maintenance and screening services, to intermediate and skilled nursing care. The capacity of local communities to meet these needs has a direct bearing on the older persons' ability to remain independent and avoid the need for institutional care. The desired goal is a continuum of services available at the local level. In many communities throughout North Dakota, this continuum of services consists of part service, part gap, and part promise.

It would like to focus on two service programs which have significant impacts on meeting the needs of older persons and have contributed significantly to the capacity of older persons to remain in their own homes. I will focus primarily on the health components of these service programs.

First, the social services block grant.—The social services block grant provides Federal funds to North Dakota for a number of social services. North Dakota received a 23-percent reduction in social service block grant dollars during the current fiscal year. North Dakota received $8.9 million in fiscal year 1981, and will receive $6.9 million in fiscal year 1982. If the administration's fiscal year 1983 proposed budget is passed, we will receive 18 percent less Federal dollars during fiscal year 1983.

Two services currently provided under this block grant are of particular importance in assisting older persons to remain in their own homes, namely, homemaker services and home health aide services. Homemaker services provide a variety of help needed by the older person. In one home she may do light housekeeping and laundry. In a second she may prepare meals, do grocery shopping, or teach selected household skills. In a third, she may provide transportation for a medical appointment.

Home health aides do the same thing that homemakers do, but they also provide personal and supportive health care under the direction of a qualified nurse. The home health aide is trained to take temperatures and blood pressures, do passive range of motion exercises, assist with ambulation and medication, and to give tub or bed baths.

For the period July 1, 1981, to September 30, 1981, 3,237 different individuals received 46,396 hours of homemaker and home health aide services. Of these approximately 62 percent were 75 years and older and 25 percent were between the ages of 60 and 74 years. Thus, 87 percent of all homemaker and home health aide services for the aforementioned period were provided to persons 60 years and older.

The Older Americans Act is the second Federal program I will address.—The Older Americans Act has provided a foundation for developing a partnership among Federal, State, and local jurisdictions and the private voluntary sector in the provision of health and social services to older persons. Federal budget reductions are threatening the partnership we have been able to develop in North Dakota. Federal cutbacks in funding the Older Americans Act during fiscal year 1982 amounts to 4.5 percent.

The proposed cutback for fiscal year 1983 is set at about 9 percent (North Dakota received $3 million in fiscal year 1981, $2.9 million for fiscal year 1982, and a proposed $2.6 million for fiscal year 1983). These cutbacks will result in reductions in services available to older persons.

A major problem for elderly North Dakotans is the nonaccessibility to needed services. A number of services funded under the Older Americans Act are directed toward assisting older persons to access services and to link them with available resources. Those services which facilitate access include transportation, information and referral, and outreach.

Other services are provided to impaired elderly persons who cannot leave their home to obtain help. These services are identified as in-home services and enable individuals to remain in their homes. These include: Shopping assistance, friendly visiting, chore services, telephone reassurance, and home-delivered meals. Still other services provided under the Older Americans Act are more preventive and are directed toward helping active older persons maintain their independence and well-being. These include: Health maintenance and screening, educational services, congregate meals, and a variety of social and recreational activities provided by senior centers.

The health maintenance and screening services provided under title III of the Older Americans Act are particularly important to older persons living in rural North Dakota. During the previous 3 months, North Dakota spent an estimated 21 percent of its title III dollars on health services to 2,361 different older persons who received 15,762 units of services. These health services included, among others, blood pressure checks, diabetes detection, glacoma tests, weight control, hearing evaluations, dental checks, foot care, hemoglobin tests, and visits to the homebound and ill. The Federal III–B dollars spent on health screening and maintenance activities generated significant amounts of donated volunteer time by medical personnel. For example, a podiatrist, physician, dentists, and nursing students donate their time at the Burleigh County Senior Citizens Center. Similar volunteerism by medical personnel is found in numerous other senior centers throughout the State.

Older persons place very high priority on health services. Health services is one of the most highly utilized supportive services provided under title III–B in North Dakota. Health screenings provided within senior centers have proven to be cost-effective, accepted by the elderly, and, when provided in conjunction with other services such as transportation and outreach, are able to span a wide segment of the older population.

In closing, let me recognize that we are in a time of change and programs designed to provide medical and social care for older persons are caught up in this change. A major concern is the rapid increase in the cost of medical care. The contributions that services provided under the Older Americans Act and the social services block grant can make to preventing and reducing the need for institutional care of elderly persons must not be minimized. There is very strong support among older persons throughout North Dakota for the services funded under these two major programs.

Senator BURDICK. Rodger Wetzel.

STATEMENT OF RODGER WETZEL, BISMARCK, N. DAK., DIRECTOR, OPTIONAL SERVICES PROJECT, STATE OF NORTH DAKOTA

Mr. WETZEL. My name is Rodger Wetzel. I am currently the director of the optional services project, which is headquartered in the State office of aging with the department of human services.

I am a native of the State of North Dakota, and my parents are semiretired farmers. I don't think farmers ever retire when they stay on a farm. They live in a county with no hospital, or no nursing home, and few community and in-home services for older people, so I have also a personal concern about the services available to older persons in North Dakota.

The goal of the optional service project is to make service options available to older people who need some kind of service or services over an extended period of time. Those services might be provided in an institution, such as a nursing home; or they may be provided in the person's home, or somewhere else in the community, such as here at the Burleigh County Senior Center.

This project came about because there were a number of people, including legislators, service providers, older people like yourselves, and family and friends of older people who believed that something must be done now to address these service needs, these long-term or extended service needs of older people.

We are trying to do three things with this project. First of all, we are studying the services that are available and the service system that we have. Burleigh County has been selected as the initial project site.

Our second objective is to pull together some providers and consumers and make some recommendations as to how we can improve the services that are available or to implement additional services if that might be necessary.

Later on this year, we hope to be able to implement some of those recommendations or make some improvements, as time and resources allow.

Senator Burdick commented initially about the increase in the number of older people in our country. Let me just give you some brief examples, referring to Burleigh County.

We have about 4,500 people over the age of 65 living in Burleigh County, according to the 1980 census. About 29 percent, or not quite one out of three, live alone. And of course that raises some initial concerns because the husband, wife, son, or daughter is not there to help them with daily living tasks.

One of our major population groups "of concern" is the over age 75 age group, because very often these are the people we see entering institutions. We have about 1,800 people over the age of 75 in Burleigh County, quite a large number. Most of them are women. Many of them are living on a limited income. Many of them do not have a family member near.

If we jump up to the next age group, the over 85, we have seen a 43-percent increase in the last 10 years, which means we almost have half again as many people over the age of 85 in Burleigh County, as we did 10 years ago. And that is true statewide in the last 10 years. That is the fastest growing group of people, the very old, the over 85, most of whom need some sort of ongoing medical care and other services.

In Burleigh County we have many good providers, I believe. We have about 25 major providers, providing about 50 specific services. But when you look at the number of telephone numbers or agencies or programs that an older person, or a family, has to know to be able to get in contact with each of the services that might be needed, there are approximately 130 different telephone numbers, agencies or programs that are providing either information, services, or financial assistance to an older person in Burleigh County. I think that says something unto itself.

We are concerned about rural and urban differences. For example, the older person living here in Bismarck may very well have services available to him that a person living in Wing, Sterling, or Regan may not have available. I am particularly concerned about rural communities because very often we are seeing these becoming increasingly and increasingly older.

The young people are not staying in rural communities. There aren't many businesses, and in many cases there isn't even a minister as a care giver to fall back on, because now he is serving three different communities.

We are too early in the project to make any specific recommendations, but there are some observations that I think I can make at this time.

First of all, we know we have a lot of providers. That is a plus, but it also can be a minus because older people might become confused either dealing with 25 or so major providers or the 130 different telephone numbers to have to try to keep track of.

I think we need an improved information and referral system, somebody who knows something about those 130, and who can give adequate and up-to-date information, and help make appointments if necessary. And since funding changes from year to year and services change from year to year, it is not the kind of thing that you can do once. It needs to be done on an ongoing basis.

There are a number of older people who need someone to help them manage going to the hospital, going to the nursing home for 3 or 4 months, and back home, when some concentrated services are needed. Maybe later on services won't be so concentrated. So many older people are just bewildered by that maze of services and providers, and need someone to help them with applications and referrals, or just sitting down and planning out those services. This case management service seems to be needed, but many agencies just do not have the staff nor the resources to do it, or perhaps a regulation or some other standard or law limits them from doing this.

Some services are available only Monday through Friday, some are available only once a day, some are not available on weekends or on holidays. Very often the services are provided, not based on what the client or the older person really needs, but rather on what is convenient for the agency, or what the agency believes it can provide.

We also have differences in eligibility standards. And we have some people who will not touch some services with a 10-foot pole because they still have that "welfare" stigma. And many agencies claim that they just don't have the funds to develop services as they are needed.

I would also observe that we don't have the kind of coordination between agencies that is needed. I visited personally and informally with about 25 agencies' administrators who would say that we just don't have the time; or we don't have the staff to really sit down and spend a lot of time dealing with the same older person. We certainly do have gaps in the services, and Senator Burdick mentioned that earlier.

Here in Burleigh County, for example, we don't have enough housing with services available if people need them. If they don't need them fine. If they need them they are there, available 24 hours a day, 7 days a week.

We don't have the kinds of emergency services available such as with your furnace, if you wake up in the middle of the night and it is off and you don't know who to call. Maybe the service is available, but you just don't know who to call.

Or you need someone to come in and stay with your spouse because something has come up and you have to attend to this other matter.

We don't have sufficient chore services, I believe. We also need attendant services, not necessarily to do a lot but just to be there. You might call that respite or homemaker service, but there seems to be a need for that kind of service.

I mentioned earlier the need for information and referral services and the need for case management or a person to help that older person negotiate the maze of services and providers.

I might add that not only do we have people in the community who are not receiving services they need, but I think there are some people who may benefit from some institutional services who should spend some time in the institution.

I also think there aren't enough incentives for our institutions in the small communities to reach out. For example, if a small community has only a small hospital or it has only a small nursing home, I don't think enough incentives are there to have them bring their services out of their facility to older people who want to stay in their own homes in the community.

We will be addressing these issues further on in the year, meeting with the providers and consumers and older people like yourselves. But I certainly think we have come up with some observations that need our attention.

I would like to summarize by saying we know we have more and more older people, and we also know we have limited resources. Unless we act together to address this issue of long-term services, we are not going to have any winners, only losers. And the people who are going to be the victims or lose the most are going to be the older people who need those very services.

Thank you.

Senator **Burdick**. Thank you.

Before I go into the questions for you two gentlemen, I thought I would let you know that the Committee on Aging is now working on a bill to reauthorize congregate housing services and specialized housing construction for the elderly.

The first question is, either one of you can answer, of all of the kinds of long-term care services, nursing homes, home health care, community support, which are the ones you find to be least available? Which are the biggest gaps in the relation to the demand for services? And does it vary by area of the State? A three-part question. Who wants any part thereof?

Mr. **Brewster**. Senator, I think there is a need for all three, but the one I think appears to be the most needed is in-home health services. I think the other thing that there is a gap statewide is in congregate housing whereby older people can reside in a congregate facility where medical services and other services can be close at hand so they can feel secure that if they do need help, that help is readily available to them.

We do have examples of that within the State, and I think older people really feel the need for such facilities. It is a transition service between living in their own homes and eventually needing nursing home care. And I think there is also a need for nursing home care at some point.

Senator **Burdick**. Any comments from you, Mr. Wetzel?

Mr. **Wetzel**. I would just like to comment on the fact that there are not consistent services across the State and it does matter where you live in North Dakota. It also matters where you live in Burleigh County, whether you are out at Regan or in Bismarck.

Some brief examples of that would be title XIX or medicaid, which has basically the same availability and eligibility. But if your county doesn't provide title XX homemaker or home health aide services adequately, you just don't have them. If there aren't funds to fund a congregate or home-delivered meal in that county, you just don't have it. So I think this is one of the problems. Sometimes older people need to move around, to move out of their own homes or their own communities just to get to a community which has the kind of care they need, and this movement causes additional problems.

I believe all three are needed too. I hear a demand for more types of in-home services that are available when the older person needs them, flexible in-home services, both medically related and meeting other kinds of needs, whether it is helping with the laundry, homemaker kinds of services, or just doing some fix-up kinds of things; the person or the service is there when the older person needs it.

Senator **Burdick**. Thank you.

The demonstration program you have described sounds like a good start to develop a true continuum of care. This is the phrase the "experts" use to mean that the right kinds of services are available at the right time for the elderly people whose needs are changing.

Will there be a study of this kind undertaken?

Mr. **Wetzel**. Yes; as time and resources allow, we will certainly be doing a concentrated study of Burleigh County. Again we are limited in terms of staff, time, and in funding for this; but we hope to gather information on a statewide basis so that we will be able to help the agencies and the providers, statewide, address the issue of long term.

But we believed it was important to choose a limited geographical area and try to do some intense studying and make and implement recommendations so that we have some specific results that we might share with the rest of the State.

I am very pleased with the kind of interest and cooperation that I have received from the range of providers, whether they be the nursing home administrators or home care providers. I think there is common recognition that something has to be done. We simply aren't going to have the funds and the resources to continue going our separate ways and doing the things that we want to do.

Senator **Burdick**. It seems to me that the most vulnerable group of people, those who might be most in need of some kind of assistance, are those who are very old and who don't have families close by anymore. Everybody always says that people living in rural areas are much more likely to have families to help them. I sometimes wonder if this is true.

What is the situation here in North Dakota? If we are not rural, no one else is.

Do you find that the most elderly are with families, or do we have a lot of people living alone?

Mr. WETZEL. I think there are some strengths in rural areas. I think by and large we know in our rural areas who is in town and who is old. But I think Mildred Monke touched on this issue, that is, neighbors and friends are fine, but when you need some critical service, you just can't call upon them. They are just not there. So again I think we have the concern, but I think it is a myth that relatives and families are always going to be there, and this assumption is losing some of its validity. Those assumptions aren't as valid as they once were.

The big farmhouse doesn't hold the three-generation family any more. The younger families are on the move. They are moving out of State in many cases, or the rural wife is working in town. The primary care giver, as most research indicates, is probably the middle-aged woman who in the past has been taking care of mother and father and mother-in-law and father-in-law. If you follow both rural and urban trends, the age group that is most likely going back to work just to bring in a paycheck is that middle-aged woman, who either believes that she has to work to help the kids through college, or to save something for her retirement, or she just happens to enjoy working and feels that this is her right.

So I don't think we can assume that in rural areas we don't need the services. In fact because we have so few services and because we don't have the ability to bounce between one agency and another to find the appropriate services, we need some services more intensely.

I would say, for example, that information and referral, and older persons having someone come into their own homes, are needed.

I think there is a certain mistrust of strangers, and again Mildred touched on that. In rural areas, very often the older person wants someone to provide the service who they know and trust. That is a big part of the rural mentality. Sometimes that can be a detriment in terms of accepting a service. But I think it says something we need to pay attention to.

We have to deal with providers who are known to the older people and accepted by them.

Senator BURDICK. Well, what are the mechanics of taking care of or watching over, in some degree, an elderly person living alone in a small town?

Mr. WETZEL. I guess first of all I think it is important to know something about the older person's own situation. Does he have family? Does she have sons or daughters? One thing that I think we can't afford to do, and we have heard this before, is to replace the natural helping network. I believe there are neighbors who are willing to do something; there are family members who are willing to do something.

I believe that we need to look at a single contact approach—the buck should stop somewhere. Somebody should be able to work and to get to know that older person and develop a case plan if we want to call it that, or sit down with him and help map out: What can your sons and daughters do? What can your husband or wife do? Where do you need help? When do you need it? So I guess I see a number of efforts needed in that direction.

I see our outreach workers with our senior programs doing some of that, but they are limited by their funding. We see social workers in hospitals and social workers in the county social service office doing some of that, but again they are very limited on staff.

So I see a need for funds for those kinds of efforts in rural areas—the outreach efforts, people who go out to the small town who won't necessarily do everything but who will help that older person decide what is it going to take to help him stay in his own home. And negotiating with agencies where necessary to find out can they provide the service on weekends and holidays as well as Monday through Friday.

Mr. BREWSTER. The only thing I could add to that, Senator, is that we also need to look in the rural community at what resources are available in addition to the natural helping network and not overlook those resources, and there are many.

Senator BURDICK. Well, thank you, gentlemen. I hope you stay around because when we get all through with the panels we are going to submit you to the questions of the multitude. We may have some good ones.

At this point, I am going to insert into the record the statement of Dale Moug, director, North Dakota Department of Human Services.

[The statement of Mr. Moug follows:]

STATEMENT OF DALE MOUG, DIRECTOR, NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES, BISMARCK, N. DAK.

Publicly funded health care under the North Dakota medical assistance program provides a broad range of medical services for the elderly. The program is one of the Nation's most comprehensive in that nearly all of the optional services are provided in addition to those required by Federal law. The number of individuals to whom the services are made available is significant due to the State's election to provide eligibility to both the categorically and the medically needy.

The program's efficiency is attributable in large measure to its administration at the county level. This, coupled with broad professional provider participation in the program, reflects a responsive publicly financed health care system for our elderly.

Over one-third of the 32,000 individuals receiving benefits under the medicaid program in fiscal year 1981 were over the age of 60. Of the $61 million expended in fiscal year 1981, over $35 million were spent on behalf of the State's elderly.

Federal initiatives brought about under the 1981 Omnibus Budget Reconciliation Act had significant impact on the State's medical assistance program. As a result of the decrease in Federal financial participation (3-percent reduction in Federal financial participation in 1982 and 4-percent reduction in 1983) under the program, there has been approximately a $7-million reduction in available program dollars for the 1981–83 biennium. This reduction in the Federal matching rate, from 62 percent in fiscal year 1981 to 59 percent in fiscal year 1982, may require: (1) The addition of State general funds to offset reduced Federal funding; or (2) the elimination of certain optional program services; or (3) the reduction in the rate at which reimbursements are made to providers; or (4) a combination of one or more of the above.

Following its Easter recess, the Congress will have before it for consideration several measures relating to the medicaid program. One of these measures calls for a program "swap." The Federal Government would administer and fund the medicaid program, and the States would assume full responsibility for the AFDC and food stamp programs. Unknown at this time, and precluding any meaningful analysis of the proposal, is the extent to which North Dakota's medicaid program will be picked up by the Federal Government. What if, for example, the Federal Government picks up only the now mandatory program services on behalf of only the categorically eligible? Under this arrangement, three-fourths of the program services would be eliminated. Two-thirds of the costs would either be passed on to the State or the services would be lost. Alternatively, it is projected that the State of North Dakota would save $24 million under the swap, assuming the Federal Government takes over and finances the medicaid program as it presently operates in North Dakota.

Another proposal which may be considered by the Congress would cut Federal financial participation for those payments made on behalf of the medically needy as well as payments for optional services. At the time of this writing, a reduction of 3 percent in Federal payments is under consideration (59 percent Federal financial participation in these optional features for fiscal year 1982 to 56 percent in fiscal year 1983).

If the "swap" results in less than a full Federal takeover of the medical assistance program, or should there be greater reductions in Federal financial participation, there is a serious potential that publicly funded health care services for the elderly may suffer. Unavoidably, we will need to redouble our cost-containment efforts. In examining alternatives, we will be looking at:

(1) Quality of care considerations.

(2) An assessment of the utility and effectiveness of existing controls such as medical review, utilization review, and professional standards review.

(3) Cost-sharing proposals and deductibles in avoiding any overutilization; and

(4) Alternatives to traditional health care approaches which may permit receipt of appropriate services in noninstitutional community-based living arrangements.

As Federal proposals unfold, we will be making careful evaluations and analysis to insure continued adequacy of publicly provided medical services for our elderly. In the meantime, we will pursue cost-containment alternatives and seek Federal waivers to allow for the development of new and innovative mechanisms for the provision of responsive and minimally intrusive services for our elderly.

Senator BURDICK. The third panel will please come to the table. They are Peggy Jukkala, Robert L. Howe, and Allan Engen.

You can proceed as you wish.

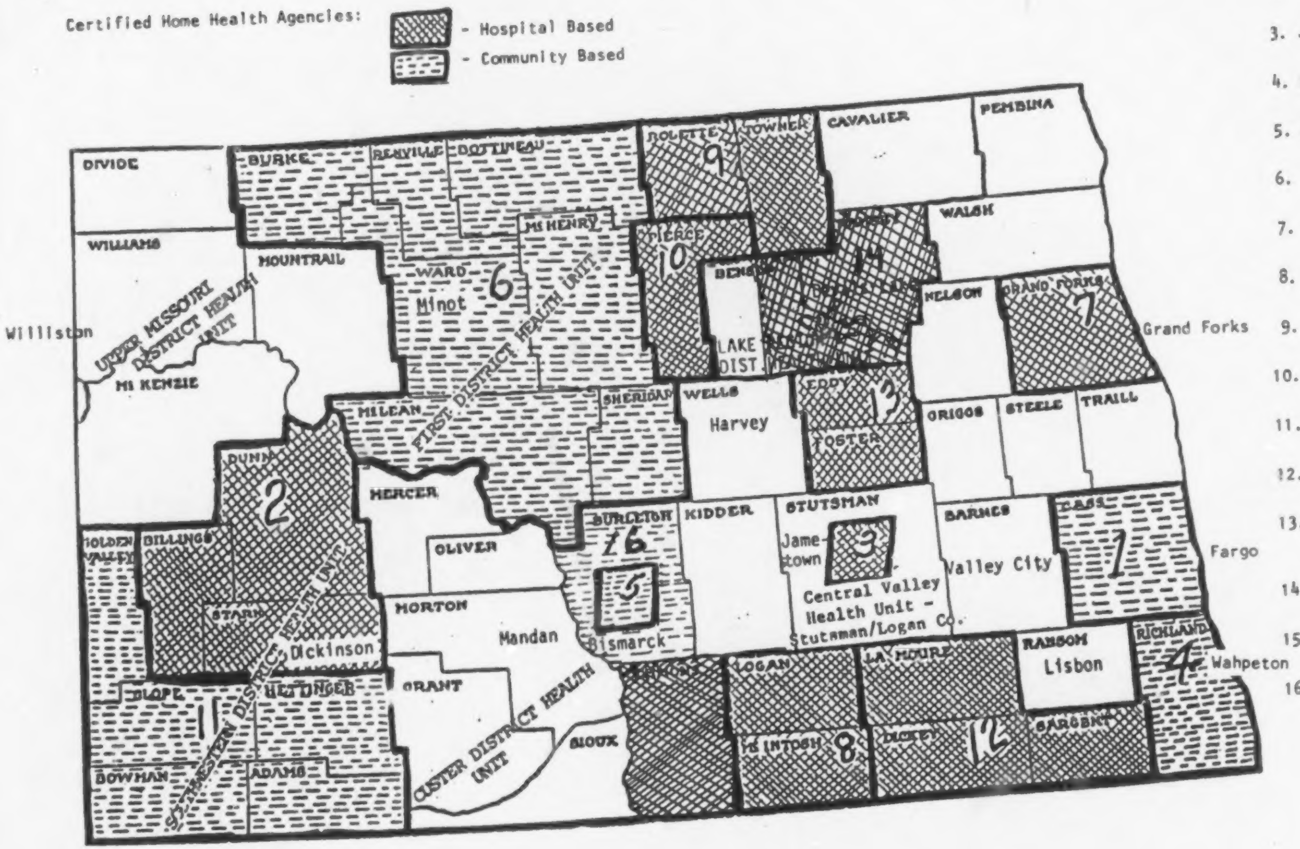
STATEMENT OF PEGGY JUKKALA, DIRECTOR, JAMESTOWN, N. DAK., HOSPITAL HOME HEALTH AGENCY

Ms. JUKKALA. Good afternoon.

I am Peggy Jukkala, director of the Jamestown Hospital Home Health Agency. I am immediate past president of the North Dakota Association for Home Health Services and a member of the North Dakota State Health Council.

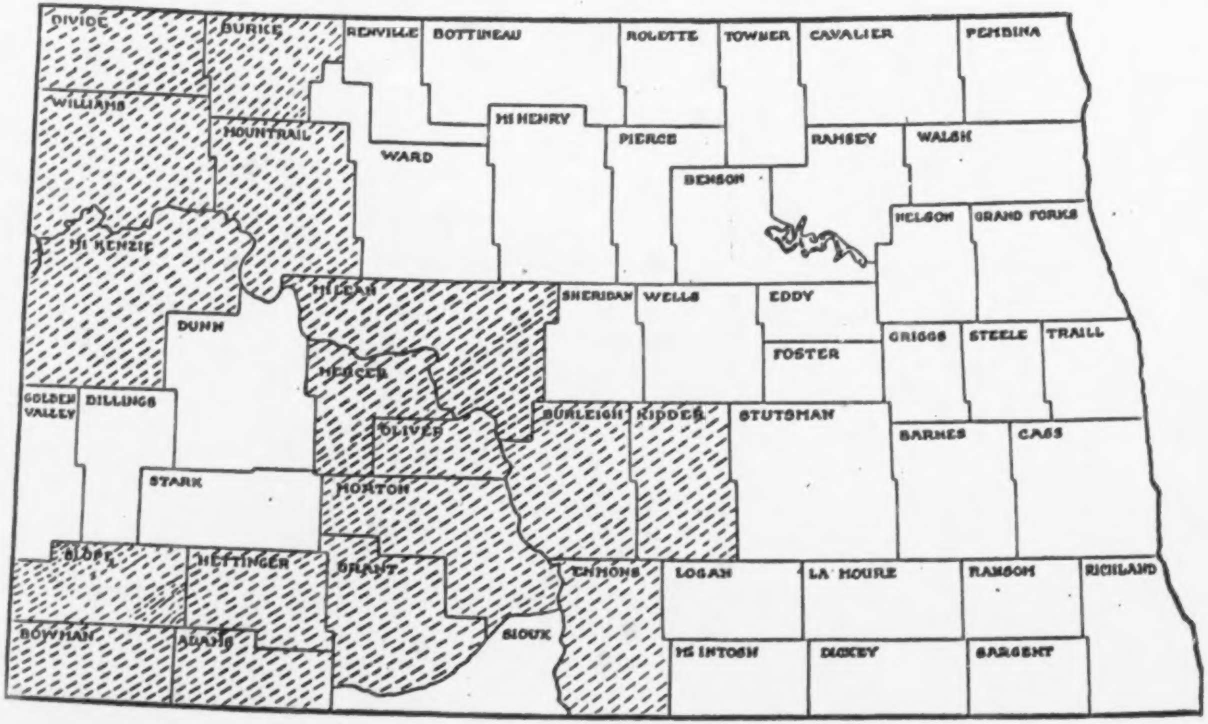
In North Dakota there are 16 certified home health agencies. We have three types of agencies—six community-based, nine hospital-based, and one proprietary agency. [See following charts and table.]

HOME HEALTH SERVICES IN NORTH DAKOTA


Certified Home Health Agencies:
▨ - Hospital Based
▤ - Community Based
DIVIDE
BURKE
RENVILLE
BOTTINEAU
ROLETTE
TOWNER
CAVALIER
PEMBINA
WILLIAMS
MOUNTRAIL
WARD
Minot
MC HENRY
PIERCE
BENSON
WALSH
NELSON
GRAND FORKS
Grand Forks
Williston
UPPER MISSOURI DISTRICT HEALTH UNIT
MC KENZIE
FIRST DISTRICT HEALTH UNIT
LAKE DIST.
MCLEAN
SHERIDAN
WELLS
Harvey
EDDY
FOSTER
GRIGGS
STEELE
TRAILL
DUNN
MERCER
OLIVER
BURLEIGH
KIDDER
STUTSMAN
Jame-town
BARNES
Valley City
CASS
Fargo
GOLDEN VALLEY
BILLINGS
STARK
Dickinson
MORTON
Mandan
Bismarck
Central Valley Health Unit - Stutsman/Logan Co.
RANSOM
Lisbon
RICHLAND
Wahpeton
SLOPE
HETTINGER
GRANT
CUSTER DISTRICT HEALTH UNIT
SIOUX
EMMONS
LOGAN
LA MOURE
MC INTOSH
DICKEY
SARGENT
SOUTHWESTERN DISTRICT HEALTH UNIT
BOWMAN
ADAMS
1
2
3
4
5
6
7
8
9
10
11
12
13
14
16

1. Fargo Community Health - Fargo
2. St. Joseph's Hospital - Dickinson
3. Jamestown Hospital - Jamestown
4. Richland County Home Health Agency - Wahpeton
5. Bismarck City Nursing Service - Bismarck
6. First District Health Unit - Minot
7. The United Hospital - Grand Forks
8. McIntosh County Memorial Hospital - Ashley
9. Prairieland Home Health Agency - Rolla
10. Good Samaritan Hospital - Rugby
11. Southwestern District Health Unit - Dickinson
12. Oakes Community Hospital - Oakes
13. Eddy-Foster County Home Health Agency - New Rockford
14. Mercy Hospital Home Health Agency - Devils Lake
15. Home Care Services, Inc. - Bismarck
16. Burleigh County Nursing - Bismarck

PROPRIETARY HOME HEALTH AGENCIES


DIVIDE
BURKE
RENVILLE
BOTTINEAU
ROLETTE
TOWNER
CAVALIER
PEMBINA
WILLIAMS
MOUNTRAIL
WARD
MC HENRY
PIERCE
BENSON
RAMSEY
WALSH
NELSON
GRAND FORKS
MC KENZIE
MC LEAN
SHERIDAN
WELLS
EDDY
FOSTER
GRIGGS
STEELE
TRAILL
DUNN
MERCER
OLIVER
BURLEIGH
KIDDER
STUTSMAN
BARNES
CASS
GOLDEN VALLEY
BILLINGS
STARK
MORTON
SLOPE
HETTINGER
GRANT
EMMONS
LOGAN
LA MOURE
RANSOM
RICHLAND
BOWMAN
ADAMS
SIOUX
MC INTOSH
DICKEY
SARGENT

▨ Home Care Services Inc., Bismarck, ND

NORTH DAKOTA STATE DEPARTMENT OF HEALTH, DIVISION OF HEALTH FACILITIES—HOME HEALTH AGENCIES

City	License No.	Home health agency	Administrator	Nurse supervisor	Services offered	Areas served
Ashley	401	Ashley Hospital HHA, 612 Center Ave. North, 288-3433.	Leo Geiger	Alice Spiekermeier	NSG, HHA	Dickey, Emmons, Logan, LaMoure and McIntosh Counties.
Bismarck	402	Bismarck Home Health Agency, City Nursing Service, 409 West Front Ave., 222-6525.	Doris Fischer, R.N., director	Doris Fischer	NSG, HHA	City of Bismarck.
	417	Burleigh County HHA, 514 East Thayer Ave., 222-6671.	Karen Deckert, R.N.	Karen Deckert	NSG, HHA	Burleigh County.
	403	Home Care Services, Inc., 601 Bismarck Ave., 258-2310.	Lou Demarais, director	JoAnn Ferrie	NSG, HHA, PT	Adams, Bowman, Burke, Burleigh, Divide, Emmons, Grant, Hettinger, Kidder, Logan, McKenzie, McLean, Mercer, Morton, Mountrail, Oliver, and Williams Counties.
Cavalier	418	Pembina County Memorial Hospital HHA, 205 3d Ave., Box M, 265-8461.	Ruth Hollis	Margaret Gadaire	NSG, HHA, PT, RT	Pembina County.
Devils Lake	416	Mercy Home Health Agency, East 7th St., 662-2131.	Marlene Krein	Grace Sharbono	NSG, PT, RT	Ramsey and eastern Benson Counties.
Dickinson	404	St. Joseph's Hospital's Home Health Service, West 7th St., 225-7200.	Rose Marie Derks, associate administrator.	Gloria Krein	NSG, PT, ST, HHA, OT	Billings, Bowman, Dunn, Golden Valley, Slope, and Stark Counties.
	405	Southwest District Home Health Agency, Pulver Hall, DSC, Box 1208, 227-0171.	John E. Fields, area public health administrator.	Darlene Barthel	NSG, ST, HHA	Adams, Billings, Bowman, Dunn, Golden Valley, Hettinger, Slope, and Stark Counties.
Fargo	410	Fargo Community Health Center, 401 3d Ave. North, Box 728, 241-1360.	D. H. Lawrence, M.D., health officer.	E. Louise Gronlund	NSG, OT, PT, ST, HHA	Fargo Cass County.,
Grand Forks	406	United Hospital Home Health Care Services, 1200 South Columbia Rd., P.O. Box 6002, 780-5564.	Robert M. Jacobson, president	Katherine Pfeifle	RN, aide, RT, MSW	Grand Forks County.
Jamestown	412	Jamestown Hospital HHA, 419 5th St. NE., 252-1050.	Richard Hall, president	Peggy Jukkala	NSG, PT, ST, HHA	City of Jamestown.
Minot	407	First District HHA, 801 11th Ave., SW, P.O. Box 1268, 852-1376.	O. S. Uthus, M.D., district health officer; Molla Romine, administrative officer.	Penny Hamilton	NSG, PT, ST, HHA	Bottineau, Burke, McHenry, McLean, Renville, Sheridan, and Ward Counties.
New Rockford	415	Eddy/Foster County HHA, 214 2d Ave. South, 947-2411.	Sister Mary Alice Reiland	Sister Mary Alice Reiland	NSG, HHA, MSW, RT	Eddy and Foster Counties.
Oakes	408	Oakes Community Hospital HHA, 314 South 8th St., 742-3291.	Sister Mary Jane Reiber	Kathy Schuman	NSG, HHA, PT, ST	Dickey, LaMoure, and Sargent Counties.
Rolla	411	Prairieland Home Health Agency, 213 3d St. NE., 477-3161.	Jack Hamlett	Sister Joanne Wieland	NSG, PT, HHA	Rolette and Towner Counties.
Rugby	409	Good Samaritan Outreach Home Health Services, 776-5261.	Ronald Waltz, executive director.	Lila Seil	NSG, OT, PT, MSW, HHA	Benson, and Pierce Counties.
Valley City	419	City-County Home Health Agency, Barnes County Courthouse.	Erma G. Overby	Erma G. Overby	NSG, HHA, PT, OT, ST	Barnes County.
Wahpeton	413	Richland County HHA, Box 226, 642-6307.	G. L. Wiltse, M.D., county health officer.	LaVonne Rustvang	NSG, HHA	Richland County.

Ms. JUKKALA. There are two major gaps in the delivery of home health care to the aged. First, there are areas in the State where there is no home health agency. There is a wide gap between the need for continued health care and the coverage requirements of the program.

First off, in a rural State like North Dakota, we have people living long distances from a potential agency located in a city that could deliver the health care needed. There are now new agencies at the present time filing notices of intent that will maybe fill these gaps.

The second major gaps deals with the medicare requirements for certification. Medicare will not reimburse for any preventive care or care after the patient's health has stabilized.

If we were permitted to give home care to these frail individuals who have serious medical and social problems, there would not be the need for frequent rehospitalizations and early placement in a skilled facility.

With a minimum observation and prevention program to set up and/or supervise modifications, check vital signs, do patient teaching, and allow a patient to reach their maximum functioning in their own homes, this would be cost-effective and patient preferred.

I do not see home health as an alternative to nursing home placement. The goal of long-term care is for the right person to be receiving the right services, at the right time, in the most appropriate place, based on one's own individual strengths and needs. Home health is one of the services that should be available.

We offer services on a continuum of care—integrating both community and institutional services, health, and social services. We attempt to avoid duplication, overlaps, and gaps in service, and to provide continuous services as long as the individual is in need and between levels of care. At some point, the health status of a person might need nursing home placement just as he or she might need acute care or they might need home health care or hospitalization, then the appropriate referral is made.

There have been charges made that home health costs the same as a skilled nursing facility and/or intermediate care facility. Nationally, there is no sound uniform statistical data available. North Dakota is the first uniform statistical data available. North Dakota is the first State to develop such a uniform method of reporting. This was implemented January 1, 1982. The statistics from all the North Dakota home health agencies show the average charge per day for a patient in home health is $12.72. After 6 months, we will be able to give you statistics on total days on service, average length of stay, total charges for services, average charge per day, and average charge per patient [see following exhibit A].

EXHIBIT A

STATISTICAL DATA COLLECTION TOOL REPORT FORM
NORTH DAKOTA ASSOCIATION FOR HOME HEALTH SERVICES

MONTHLY REPORT ____________________, 19___

AGENCY NAME: ____

No. of patients receiving services at beginning of month ______
No. of new patients admitted during month ______ YTD: ______
No. of patients re-admitted during month ______ YTD: ______
Total patients admitted during month ______ YTD: ______
Total patients on service during month ______
No. of patients discharged during month ______ YTD: ______
No. of patients on service at end of month ______

ADMITS: ______

Referral Source: YTD

_____ Self _____
_____ Family _____
_____ Physician _____
_____ Hospital--Inpt. _____
_____ Hospital—Outpt. _____
_____ Hospital--Soc. Work _____
_____ Public Health _____
_____ Long Term Care Facility _____
_____ Transfer between HHA _____
_____ County Social Services _____
_____ Other _____

Age:

	Male	YTD Male	Female	YTD Female
0 - 4				
5 - 9				
10 - 14				
15 - 19				
20 - 34				
35 - 44				
45 - 64				
65 - 74				
75 - 84				
85 +				

Race: YTD

_____ White _____
_____ Black _____
_____ Oriental _____
_____ Hispanic _____
_____ Amer. Indian _____
_____ Other _____

Living Arrangements: YTD

_____ Alone _____
_____ With other(s) competent to assist with care. _____
_____ With other(s)—No assist with care _____

County Codes:

TOTAL PATIENTS ON SERVICE: ______

Third Party Payor:

_____ Medicare
_____ Medicaid (Tital XIX)
_____ Commercial Insurance
_____ Self Pay
_____ Title XX
_____ VA
_____ Workmen's Comp.
_____ Other

Visits by Service: YTD

_____ RN _____
_____ LPN _____
_____ Home Health Aide _____
_____ Occupational Therapy _____
_____ Speech Therapy _____
_____ Physical Therapy _____
_____ Respiratory Therapy _____
_____ Medical Social Work _____
_____ Other _____
_____ Total _____

PATIENTS DISCHARGED: _______ YTD:_______

Reason for Discharge:		YTD
_____	Pt. rehabilitated	_____
_____	Pt. stabilized	_____
_____	Moved out of service area	_____
_____	Deceased at home	_____
_____	Admitted to inpt. hospital	_____
_____	Admitted to nursing home	_____
_____	Home care inappropriate	_____
_____	Other	_____

Diagnosis:

YTD	Primary		Secondary	YTD
_____	_____	Arthritis	_____	_____
_____	_____	Cancer	_____	_____
_____	_____	Cardiovascular	_____	_____
_____	_____	Cerebrovascular	_____	_____
_____	_____	Diabetes	_____	_____
_____	_____	Gastrointestinal	_____	_____
_____	_____	Hematological	_____	_____
_____	_____	Neurological	_____	_____
_____	_____	Ophthalmology	_____	_____
_____	_____	Orthopaedic	_____	_____
_____	_____	Post-Surgical	_____	_____
_____	_____	Psychological	_____	_____
_____	_____	Respiratory	_____	_____
_____	_____	Skin Ulcer	_____	_____
_____	_____	Urological	_____	_____
_____	_____	Other	_____	_____

Disposition on Discharge:		YTD
_____	Self Care	_____
_____	Family Care	_____
_____	Hospital	_____
_____	Nursing Home (SNF/ICF)	_____
_____	Residential Facility	_____
_____	Moved out of service area	_____
_____	Deceased	_____
_____	Unknown	_____
_____	Other	_____

Visits by Service:		YTD
_____	RN	_____
_____	LPN	_____
_____	Home Health Aide	_____
_____	Occupational Therapy	_____
_____	Speech Therapy	_____
_____	Physical Therapy	_____
_____	Respiratory Therapy	_____
_____	Medical Social Work	_____
_____	Other	_____
_____	Total	_____

Income Level:		YTD			YTD
_____	0	_____	_____	4	_____
_____	1	_____	_____	5	_____
_____	2	_____	_____	9	_____
_____	3	_____			

Change in Patient's Condition:

On Admission		Expected Outcome		On Discharge	
_____	Dependent	_____	Dependent	_____	Dependent
_____	Needs Assistance	_____	Needs Assistance	_____	Needs Assistance
_____	Needs Supervision	_____	Needs Supervision	_____	Needs Supervision
_____	Terminal	_____	Independent	_____	Independent
		_____	Death	_____	Death

Total Days on Service:_______ YTD:_______
Count day of admission to day of discharge for all patients discharged during the month.
Do NOT count days patient was in hospital, nursing home, etc. as Home Health days on service.

Average Length of Stay:_______ YTD:_______
Divide the Total Days on Service by the number of patients discharged during the month.

Total Charges for Services:_______ YTD:_______
Add total charges billed for services provided to all patients discharged during the month.

Average Charge per Day:_______ YTD:_______
Divide Total Charges for Services by the Total Days on Service.

Average Charge per Patient: _______ YTD:_______
Divide the Total Charges for Services by the number of patients discharged during the month.

Ms. **Jukkala**. We understand that home health is not the only cost for the taxpayer for an individual in their own home or Federal subsidized apartment. Other services, like meals on wheels, outreach worker, transportation, medical services, rehabilitative services, mental health services, advocacy programs, and counseling, all increase the cost per day.

If home health could eliminate some of the costly duplications, administrative burdens, duplicate recordkeeping requirements without decreasing the quality of care, our costs could decrease.

The North Dakota Association of Home Health Services at the present time is conducting a feasibility study that we feel will meet criteria in obtaining and sustaining medicare and JCAH requirements into a peer review program that, if accepted, will cut out duplication, be less costly, and is an informative educational review system for all North Dakota home health agencies. This could be available to areas or facilities wishing to start a new home health agency.

We feel we have the expertise in home health care, are better able to advise and consult with existing home health agencies and/or new agencies in program development for quality care to all North Dakota citizens.

Home health is a part of a continuum of care for the elderly that allows the individual to be a responsible, self-determined, integrated, functioning person in the community.

Now that is my testimony. After hearing all this, I would like to add a few more things.

The maintenance program Mr. Wetzel talks about is very good, but as you all know, you need something in your home. We have some of this started now but most of you cannot, or a lot of people cannot, get out to get this kind of care, and we need to get it into the home.

No. 1, you have got to have services available 24 hours a day, 7 days a week. You are not sick just 9 to 5, as you all know. And you have got to be able to call someone at all times of the day, plus holidays.

The homemaker health aide program is, in some areas, doing fine. In some areas, it is almost nonexistent. I would like to see closer supervision of this program with whatever is available, the health delivery system that is there. If it is a home health agency, a community health program, whatever is there—I would like to see that supervised. I would like to see the homemaker help aides have more of a training period and I would also like to see them available 24 hours a day, 7 days a week, because that again would help most everyone.

Thank you.

Senator **Burdick**. The witness you have just heard is director of the Jamestown Home Health Agency. She is representing the North Dakota Home Health Association.

The other witnesses you will hear from now are as follows:

Robert Howe, who is senior vice president of the North Dakota Hospital Association in Grand Forks. Many nursing homes belong to the hospital association. We also want to talk to Mr. Howe about how hospitals can help fill the need for nursing room beds in rural areas.

The hospital association just recently received a grant from the Robert Wood Johnson Foundation to study the hospital swing bed program.

We also have Allan Engen, who is executive director of the North Dakota Health Care Association here in Bismarck. The association represents nursing homes.

Which of you gentlemen would like to proceed?

STATEMENT OF ROBERT L. HOWE, GRAND FORKS, N. DAK., SENIOR VICE PRESIDENT, NORTH DAKOTA HOSPITAL ASSOCIATION

Mr. Howe. If it is all right, I will, in order as they appear on the agenda.

Senator, as you know, my name is Robert Howe, and I am senior vice president of the North Dakota Hospital Association. The association represents over 100 health care institutions and providers of care. That includes 42 facilities that have skilled licenses and 15 facilities that have intermediate care licenses.

Senator, I am here, like you, because of a great concern for the welfare of the people we serve; namely, the senior citizens. But we are also concerned about the ability of our members to provide the necessary care. It would be threatened if Federal or State funding were drastically reduced.

A great emphasis is placed or focused on the cost of care. There is a tendency to forget, I think, what is being provided for those dollars, to attach too quickly to the so-called alternatives that may result in fewer services being delivered, or the same services delivered, at a greater aggregate or total cost.

The point I am trying to make is for someone who needs skilled care, skilled nursing homes are the only viable cost-effective alternative. However, we do support the maintenance, expansion, and even development of other services or levels of care. I think the point I am trying to make, it is sometimes terminology. Some of our hospitals and nursing homes, as the previous witness, Peggy Jukkala testified, do provide some of those alternative levels of care, not alternatives to skilled care.

With emphasis on cost, and they are properly placed there, I would like to relate some of the things we are doing.

Senator, you just alluded to our swing bed project or program.

The swing bed program, in a few words, is an attempt to better utilize the small, rural hospital beds that are obviously underutilized or set empty, for the care of persons who need skilled care. Now this does not mean as a permanent replacement of a nursing home, but the ability to one day, as the need arises, use those beds for acute care patients, or for skilled nursing patients while they are waiting on a bed in a skilled facility to be available.

There are many advantages. Obviously, I think it makes the hospital more cost-efficient. It better utilizes the building that has already been built. It might possibly delay or eliminate the need for the building of more nursing homes; and a very large proportion of the high cost in homes, especially the new ones, is the cost of building it, the interest rate for the loans, and so forth.

Senator, I want to publicly acknowledge your assistance in getting the Federal legislation enacted in Washington, without which the swing bed concept would fail.

Now, I would also, as a matter of record—maybe some of the regulators will read this tape—state that the law was enacted, with Senator Burdick's very active support, to be effective June 1, 1981, as soon as the regulations are written.

It is now April 1982, and the regulations still have not been written, and we are very concerned. And I know you are, Senator, because everybody benefits by the swing bed concept.

We cannot deny that nursing home costs have increased dramatically. Fighting costs—I am not saying this facetiously—is a constant battle by our administrators.

The main reason for the cost increase is inflation. It has a great impact, as you all know, on the price of groceries. And I challenge anyone to have a larger grocery list than our nursing homes. And inflation also impacts on the wages they have to pay, because their employees are very adversely affected by inflation, and wages in the nursing homes are 60 percent of the cost.

Now, let me say that no one is more saddened than the staff involved when a resident runs out of funds. I would add, Senator, that inflation is one of the reasons I think the Government is spending more money, and why people are running out of money more rapidly than they did in the past.

But I would not like to see the nursing homes blamed for high costs. To blame them for it is to blame them for inflation.

Also another factor is that people are living longer. We thank God for that, but it is also a fact that the older the person is, the more services they require. In other words, the services required increase with age as does the recovery or mending period. So this is another impact on the total medical expenditure.

In summary, we, the hospitals, and nursing homes, encourage and support development of services that meet the needs of our senior citizens. And we stand ready to serve those in need of the services that we offer. And we do pledge to deliver them in the most cost-efficient manner.

I would also like to encourage you to do what you can to put back the money in the program that Aging Services provides because we do think they offer very valuable programs.

Thank you, Senator.

Senator BURDICK. Thank you.

Mr. Engen.

STATEMENT OF ALLAN B. ENGEN, BISMARCK, N. DAK., EXECUTIVE DIRECTOR, NORTH DAKOTA HEALTH CARE ASSOCIATION

Mr. ENGEN. Senator, my name is Allan Engen. I am the executive director of the North Dakota Health Care Association.

We are an association of skilled nursing homes, intermediate care facilities, and homes for the aged and infirm.

I would like to just say that because of limited time our national affiliate, the American Health Care Association, has submitted detailed recommendations for both the medicare and medicaid programs on a national level. And recently they were presented to the Committee on Finance and if this committee would be interested, I would be happy to supply a copy of those recommendations.

There are about three different areas that are of deep concern to us here in North Dakota. And I would like to just briefly cover those items.

When the hearing was opened, Senator Burdick mentioned revised regulations for skilled nursing homes that have been worked on for 4 or 5 years in the Department of Health and Human Services. And recently they were shelved, and as I understand, will not be released. I guess I would just like to say that the industry was looking at those regulations as a possible way of hopefully eliminating some of the administrative paperwork, duplication, and some of the unnecessary regulations that we have been living with for a number of years.

Also it was hoped that it would strengthen patient rights and patient care regulation in our Federal conditions and participation. I would ask the Senator to reconsider their stand on those regulations, and at least hopefully they could be released, so that at least we could provide comments on them.

Another area that we have some deep concerns on is the State medicaid program, and I understand Mr. Myatt was going to be here, but apparently he has not yet arrived.

In the long-term care facilities, approximately 60 percent of the residents that live in the facilities have their care paid in part or whole through the State medicaid program. Any changes and reductions in that program have very serious ramifications on the long-term care facilities.

Recently, the director of our human services agency under which the medicaid program is administered, appeared before a Finance subcommittee and indicated that they may have to reduce services and programs because of lack of funding.

Under the medicaid program we have both mandatory and optional services. The optional services are those services that the State chooses to provide, one of those being medically needy. Another one is the intermediate care program. Some other ones that you would probably be familiar with are drugs, mental hospital services, and so forth.

If the State should choose, they could eliminate those programs entirely. And I guess we have some very serious concerns about what would happen if that action was taken.

I guess it was just mentioned recently about the swing bed program, which the hospital association has worked on. I would like to say that we support the concept of the swing bed program, but I do have to say that it is another program that will be vying for medicaid dollars, so we have some concerns that the program is run in an economic manner.

Another area is the development of alternate services. I think we have to realize that for many years the long-term care facility provided many of the services or was the only service available to many people.

Today, we are seeing a number of our long-term care facilities and hospitals involved in the development of community services, basically because nobody else is doing it.

We do applaud the efforts being made by the Department of Aging in their evaluation and development of the services. We would like very much to see a waiver requested by the State medicaid program to permit the payment of services under community-based service regulations because I am afraid without a funding program, we will never see any real service programs developed in this State.

The last area that I want to make a comment on is the federalization of the medicaid program.

If President Reagan's proposal that the Federal Government will take over the medicaid program at some point in the future, I guess many of the concerns that we have that I just mentioned exist there.

Without a standardization of that program across the country, the Federal Government could in fact drop many of the services that we now have in North Dakota, such as medically needy, the intermediate care, the drug program, mental health services, et cetera. These are all optional services.

And I would encourage the Senator and his committee to work on that transfer so that we do not lose those needed services.

I would like to thank the Senator for this opportunity.

Senator BURDICK. Thank you very much, Mr. Engen. Your prepared statement will be inserted into the record at this point.

[The prepared statement of Mr. Engen follows:]

PREPARED STATEMENT OF ALLAN B. ENGEN

Senator Burdick, committee members, my name is Allan Engen. I am the executive director of the North Dakota Health Care Association, which is an association of skilled nursing, intermediate care facilities, and homes for the aged and infirm.

I would like to thank you for the opportunity to appear before this committee to present comments and recommendations on the topic of your hearing.

Our national affiliate, the American Health Care Association, the Nation's largest organization of long-term care facilities, recently presented detailed testimony and recommendations on the medicare and medicaid programs to the U.S. Senate Committee on Finance. If this committee doesn't have access to those recommendations and wishes to have them, I would be happy to provide a copy.

There are three general areas that I would like to present comments on to this committee.

The first is the area of regulations. The long-term care industry has become, over the past few years, the most heavily regulated industry in this country. At the time there was talk about Federal reductions on reimbursement to States under the title programs, there was discussion that the whole area of regulations would be reviewed under the leadership of Vice President Bush. The purpose being to eliminate any unnecessary regulations and thus reduce costs to both the title programs and facilities.

We have been told for months that the proposed rule for skilled nursing facilities were to be circulated and commented on with the U.S. Department of Health and Human Services, and would be released any day. Now we have been told that Secretary Richard Schweiker has decided not to release the proposed rulemaking. We were hoping that the proposed rulemaking might provide an opportunity to reduce unnecessary administrative requirements, burdensome paperwork, and duplication of regulations.

I would urge this committee to support the release of those proposed rules to permit review and comments on them.

A second area is our State medicaid program. In the long-term care facilities, the care for approximately 60 percent of the residents is paid in part or whole by the State medicaid program. So any changes in that program has serious ramifications for long-term care facilities.

In the first round of Federal reductions, we were fortunate in that money was available on the State level to claim Federal match as a result of other program reductions. So what first appeared to be a $6- to $7-million reduction for long-term care facilities ended up to be approximately $600,000. What fiscal 1983 and 1984 will be is another question.

One of our serious concerns, at this point, is the fact that State agencies have been directed to budget at 90 percent of the current biennium for the coming biennium. This could well result in percent cutbacks, caps, or just out and out elimination of programs.

In addition, we will have programs (already discussed) such as the swing bed program, which will be funded in part with medicaid dollars. We support the idea of the swing bed program, but not at the expense of existing long-term care facilities. Also, we feel that people using that program are entitled to services similar to what services they would receive in a long-term care facility.

We are seeing a lot of activity in the development of alternate services. We support this effort and encourage the development of a waiver under the medicaid program in relation to the community-based services regulations. Without a funding mechanism, the alternate services will never be developed. I do think we need to understand that alternate services are a very important part of a continuum of care program in this State, as well as the Nation, but in many cases, alternate services will be very expensive because of low utilization.

In this area, these are problems we are faced with in North Dakota, but I wanted you to be aware of our situation.

The last area is the federalization of the medicaid program. We have some very deep concerns as to what will happen to a number of programs and people in the changeover.

Federalization could well result in the loss of a whole group of people, which are now classified as "medically needy" and the elimination of entire programs, such as intermediate care, drugs, mental health services, etc.

We would encourage this committee to support the retention of existing services and categories related to groups under any form of federalization of the medicaid program.

I would be happy to answer any questions I could.

I want to thank you, Senator Burdick, and your committee for this opportunity to appear before you.

Senator Burdick. Before I go to the questions of the panel, I would like to reply to what you gentlemen just said about regulations.

The nursing home regulations covered a lot of different areas. Some of them we would like to see come out, such as patient care management. Other areas which would affect paperwork only we also support.

What we objected to is the changes in the patient rights, social services, and activities. These are going to be dropped.

Now for the questions.

Peggy Jukkala—is that pronounced right?

Ms. Jukkala. You can call me Peggy.

Senator Burdick. All right, Peggy.

Right now the Federal law does not require that there be any payment by medicare beneficiaries for home health care services; that is, there is no cost sharing.

One of the current budget proposals that has been suggested is to charge patients a certain amount—about 5 percent per visit for home health.

Can you tell me how you think that this would affect the people your agency is serving?

Ms. Jukkala. Five percent of what?

Ms. Deignan. Of the total cost per visit.

Ms. Jukkala. I would see that some people could afford that. And it might deter some people from having home health services.

I do see we have some private-paid patients because they asked to have us come in on a couple days a week visit to keep them in their homes, and they pay about what that would be right now. I am not sure how many people would be able to sustain that for any length of time. If we were allowed to take care of people without all those requirements on a weekly or say semiweekly, twice-a-month basis and just monitor them, knowing that they could call us at any time and still have medicare funds under reimbursement, somehow we could do that.

But right now we are not allowed to do that. Once the patient is stabilized, we are supposed to discharge them, and the initial cost of having a patient has already been met.

We have worked the patient up, we have done all the things that we should, find out what the family is going to help with, the support systems. We have a med setup, we know the patients, the patients know us very well. So all that is done.

And then once we get that all done, stabilize the patient, try to make them responsible for taking their meds, and eating the right food, and that sort of thing, but if we could just go in once in awhile to watch them to see that that is continuing on, we wouldn't have that rehospitalization or a nursing home placement.

Senator **Burdick**. But certainly that 5 percent I referred to would be somewhat of a burden to some people?

Ms. **Jukkala**. I would think so, it could be. If our total cost could go down, it might not be, if we could spread out our cost it wouldn't be. But it might be for some people.

Senator **Burdick**. Last year I cosponsored legislation to remove the prior 3-day hospitalization requirement for home health service. It was passed and signed as a law.

What effect will this have?

Ms. **Jukkala**. It has already had an effect.

Senator **Burdick**. Is that official?

Ms. **Jukkala**. Yes, oh, yes. Absolutely. We have patients all the time that do not come into the hospital at all, and we just treat them. But we were doing that before, like if they had part B, you could pay the $60 deductible and if they had a good supplement, why then they, most of the time, they didn't even have to pay that. It was there. A lot of the physicians just did not utilize it, they would send them into the hospital instead.

Senator **Burdick**. And in many cases, that 3-day visit was just unnecessary?

Ms. **Jukkala**. I don't know if it was all unnecessary, but it makes it a lot easier.

A lot of times we are seeing patients that just come in to be stabilized and it could be 24 hours, and before, we couldn't do that. So we are getting a lot of those patients, too.

Senator **Burdick**. The same bill removed limits on the number of home health visits that the patient could receive, depending on their need.

Would that make it easier for you to do your job, or do you have very few patients that might require more than 100 visits a year?

Ms. **Jukkala**. In the 4 years that I have been in home health, I have only had one patient. It is the criteria, the stabilization, the medicare. No program of prevention is what we see, and in some type of maintenancing. These maintenance programs are great if you can get to them. If you can't get to them, they are not going to help you.

Senator **Burdick**. How can we get more home health into rural areas? I happen to be a sponsor of a bill to provide grants through the Public Health Services to start up home health services in rural areas.

Do you think it will help?

Ms. Jukkala. It sure will.

Senator Burdick. Well, Peggy, I will leave you alone for just a minute.

Now, Mr. Howe or Mr. Engen, either one of you can answer.

Given the growing population of elderly, what do you see in the future here in North Dakota? Are we going to need more nursing home beds? What kind will it be—skilled care or lower level care? What do you see?

Mr. Howe. Well, I mentioned that as the age increases, so do the amount of services required. I think the whole thing is proper placement. If a person is properly placed and their needs met via the home health visits, fine. If it requires acute care, to assure that the acute care is only for the acute stage and there is a transfer, if it is for recuperation and not at home type, to a skilled setting, and on down the line.

I think given the ability to—or more dollars, in some of these programs, like Aging Services, and give them a chance to take hold. I think, in the long term, we may find some cost decreases. You must realize that years ago, everybody thought they should have a hospital. The Government supplied the money. Now we have too many hospitals. We are very concerned that the same thing is going to happen with the skilled nursing homes.

If you move two patients out of a skilled home, costs really don't go down. Maybe if you moved 10 out, they are able to lower some staffing, and so forth. So there is no quick solution; the problem has been building up over the years and it will take some time to solve, to change placement patterns.

I caution against the quick solution route.

Mr. Engen. Senator, I think taking what is happening in this State today with the swing bed program, the development of alternate services, hopefully we will see more State funding for that in our coming legislative session. And with the occupancy we are experiencing in our long-term care facilities, I feel that we do not need any more beds at this time.

In fact, our association came out with a position paper last year asking for a moratorium on building any additional nursing home beds.

Senator Burdick. That is why we were able to sell the swing bed concept, because we had extra beds. And I do hope the regulation will soon be adopted. We gave this authority about 1 year ago, as you recall.

What is the average cost of care per year in a nursing home? Does anybody have those figures?

Mr. Engen. I don't have privately paid, Senator, but the medicaid statewide is running about $35.50 a day, so what that would translate into as a yearly figure—I would guess that private paid is $5, $6 a day higher.

Senator Burdick. Could you tell me approximately what percentage of that care is paid for by medicaid or medicare?

Mr. Engen. About 60 percent of the people in long-term care is paid for with the medicaid program.

Senator Burdick. What percent of the bill is paid by medicaid-medicare?

Mr. HOWE. Well, I think this varies from facility to facility. In other words, what we are alluding to here is the cost shifting. There may be a shifting of costs to the private pay patient and this, as I stated, varies from facility to facility. That is what happens when Government does not pay the full cost of care. You will find a lot of facilities in which private pay and social service rates do not differ. So you ask how can they do that? Well, the main reason they can do that is because they receive contributions, and the contributors are in effect, subsidizing social services. But it varies from facility to facility.

Senator BURDICK. I am going to ask you a very realistic question. A patient is entered into a nursing home and runs out of money. What happens to them?

Mr. HOWE. Well, obviously they have to find somebody to pay the bill. And I would imagine that the steps followed then is to contact social services in the area and see if they qualify for that program.

Senator BURDICK. We are talking about welfare, I presume?

Mr. HOWE. That is right.

Senator BURDICK. I would like to make sure we have on the record exactly what problems these swing bed regulations are causing here. Is it causing any problem?

Mr. HOWE. Yes, of great magnitude. People are not getting into the program. It allows a simplified costing method, a carve-out of income, if you will, is the technical term, and that is the single most important feature of the law and regulation.

The program would survive even without serving the medicare-medicaid patients if they had the ability to use the simplified costing. However, we do not want to be able to serve all patients.

I still want the law and regulation to come out.

Senator BURDICK. When I get back to the committee, should I tell them it is very much needed?

Mr. HOWE. Very much. Since the law is in effect, maybe we should challenge the system and use the carve-out costing method without the regulations.

Senator BURDICK. This is the end of the panel questions. For one-half an hour or so we are going to open this up, as I said before, to public questions. But our stenographer is working hard, and we will have a 5-minute recess, and then all panelists will come to the front, some place here, and you can submit yourself to questions from the people.

So we will have a recess for 5 minutes.

[Brief recess.]

Senator BURDICK. Is Elizabeth Fischer in the audience?

She is recognized for 3 minutes.

STATEMENT OF WENDELIN (ELIZABETH) FISCHER, BISMARCK, N. DAK.

Mrs. FISCHER. Good afternoon. My name is Wendelin Fischer, and I have been asked by Senator Burdick's office to comment about my situation.

My husband is in a nursing home and it is going to be 8 years in July. When we took him in, he couldn't walk. I took care of him as long as I could, but he has to have nurse's care, or else I would have him home. So I couldn't—so I went and I sold my home. But I didn't get cash. I receive $18,600 each October, once a year, on a contract for deed for the property that was sold. And I have to pay $19,345 a year to the nursing home.

My husband's social security is $304 and mine is $126 a month. My rent is $325 a month. Blue Cross-Blue Shield supplement to medicare insurance was $578.40 in 1981, and I received notice this is to be increased in June 1982 for the two of us. I have car insurance, licenses for the car, utilities, medicine for my husband—which was $66.49 in March 1982—new glasses for myself were $113 for the lens only, I even used my old frames, and my husband's care at the home is $53 a day.

It doesn't take much to figure that at the end of the month, I don't have much left. In fact, I have medicine—high blood pressure pills—to buy, and in between somewhere I manage to get something to eat. If it were not for my children helping some, I would not be able to make it.

I tried to get in welfare at the county for help and they refused me.

I was behind 3 months last year and when I got paid in October, I paid those 3 months that I was behind. I had to babysit to make my living, to put bread on my table, and I have to pay my rent, and I have to pay Blue Cross and Blue Shield, and everything.

I am not well myself, I was in the hospital two times last summer, and I had eye surgery, and that goes on and on. I am 76 years old, and I have to go and work to get it going, and now I am 6 months behind this year that I can't pay up there. I have to pay Blue Cross and everything, and now I am behind.

So what shall I do, you know, to keep it going? Is there anything for the elderly person in such a situation like mine that I could be helped? What will I do when the money is gone? Who is taking care of me if I am still around?

Thank you very much.

Senator **Burdick**. Thank you.

This is Byron Knutson. I will state your name for you.

STATEMENT OF BYRON KNUTSON, BISMARCK, N. DAK.

Mr. **Knutson**. Thank you, Senator.

Thank you for coming out here this afternoon, Senator, to inquire about difficulties which we are confronted with in obtaining medical services and health care at prices that we can afford.

Alternative forms of health care have been mentioned. We should move toward development and delivery of home health care services because they may better serve the needs of some people. It is doubtful, however, if home health care services will help solve the tremendous cost problems which we are facing, nor the greater cost problems we likely will be confronted with in the future. Reduced use of hospital beds and nursing home facilities will mean that the price for services will need to be increased for those who do need to use them, because the institutions have been put in place and they must be paid for.

The uncontrolled expansion of medical, nursing home, and hospital facilities will also place greater cost pressures on the people. No one, unfortunately, seems to be in control who has a position of public responsibility. In Bismarck, we see our two hospitals involved in what appears to be wild competition, as both are expanding their bed capacity at costs of about $23 million each. This expansion is taking place even though the staff of the Western North Dakota Health System Agency determined that it was not necessary.

Now some of the things that I have to say here today I really don't like to say because they sound critical. It hurts me to be critical of people, and I am sure you feel the same. But we are confronted with a very, very serious situation which we have been addressing for a few years, but we are a long way from really getting started at solving the problem.

Many, many countries provide free health care services on a complete basis. Now, most every country in the world that provides free medical care to their people is generally thought to have far fewer resources than we in the United States.

The question is, why haven't we, over the years, been developing a system of health care delivery that is at least as good as what we find in many other countries of the world? And why haven't we been trying to make it better? That is the big first question.

Next, has our Government decided that the service wouldn't be good enough? If it has, it is certainly not correct according to what we find out by visiting and researching in other countries.

The third question: Does our Government feel that it would be too expensive to provide health care services like governments in other countries do? If the Government feels that way, it is totally incorrect. There is no research, no evidence to indicate that it is more costly for other countries to provide free health care services. In fact, it generally shows that it is even less costly.

I would like to encourage your colleagues and encourage you, Senator in the event you have some doubts about what I have just placed on the record, to go to Saskatchewan, go to Manitoba, go to Norway, Sweden, Denmark, the Netherlands, West Germany, Australia, or even Great Britain, which now has all the economic problems because of what is known over there as supply side economics, which is Reaganomics here, to find out what the people think about publicly financed health care systems. Unless there has been substantial changes in the quality and availability of health care services you will likely find the same kind of support for public financing of health care delivery systems as I have found.

Why does our Government seem satisfied to limp along behind many, many other countries who have had free medical and health services for their people for many, many years?

There isn't such a thing as a spouse losing a home in West Germany just because the other spouse may have long-term needs for nursing home care. Neither would there be loss of savings. If the Government of West Germany can do it, and Norway, Sweden, Saskatchewan, Manitoba, and the other countries earlier mentioned can do it, why can't our Government do it?

Let me address this item of cost, Senator.

While we were spending in 1979, an average of about $943 per person on health care, they were spending about $463 a year, and I will challenge anyone here to find those in Saskatchewan who will say that their health care system is inadequate. If it has been inadequate, why wouldn't they have changed their Government, because they have the same free electoral process that you and I have. In fact, they have a more open political process because they have campaign spending limits. And that makes it more of an equal match. They don't have hospital associations begging for campaign money so that they can get someone in the insurance department who will do exactly what they want them to do.

Senator BURDICK. Byron, we are working under time constraints. I want you to have every word put in the record, but I hope you can close soon because others want to say something before we close.

Mr. KNUTSON. That is very, very important.

I hope when you go back to Washington, Senator, you will tell your colleagues on the floor of the Senate that Senators and House Members, who ought to be for the people, that receiving and accepting contributions from the medical association has got to stop, or we will lose complete confidence and hope for improvement in the health care delivery system.

Thank you.

Senator BURDICK. Who is next?

Miss MONKE. Senator Burdick, I was a member of a previous panel. I just have one more subject which I would like to discuss. I don't think anybody has touched on the matter of preventative medicine or health care. I don't think preventative medicine has been emphasized at all. In my view, it is very, very important. Anything, any program we can devise that will inform people about taking care of their own health so they can cut down on visits to the hospital, to the doctor, et cetera, I think is a must for all people. This is particularly necessary for older people when we know how easily aches and pains send us all kind of messages about our health, some way off beam. We should be made more knowledgeable about caring for our own health without getting into a panic over small things.

Preventive health care is necessary.

STATEMENT OF KEITH GENDREAU, BISMARCK, N. DAK.

Mr. GENDREAU. My name is Keith Gendreau. I am chairman of the Long-Term Care General Council for the North Dakota Hospital Association and an administrator of a facility in Bismarck.

Everything that was said with the first panel I am in agreement with. It is expensive to place anybody in a long-term care facility. I do take objection to the 40- to 60-percent figure that Mr. Domrese used. We are not talking statistics, we are talking people. And when I hear 40 to 60 percent of the people in long-term care don't need to be there, to me that is a direct slap in the face for those families who have gone through that very traumatic admission into that facility. It is saying that those people should not be there and those families put them there. I don't believe so.

Bob Howe has mentioned expense. You use a facility as a very big home. When your grocery bill goes up, our grocery bill goes up. MDU says they want 30 percent, that means 30 percent of our facilities.

Back to that 40 to 60 percent Mr. Domrese mentioned, years ago that might have been the truth where people came into long-term care facilities out of their own homes, out of their apartments. That is no longer the case. These people come from hospitals where a physician has screened them and said, you need long-term care. If they are on assistance, they have that structure in place where they are screened by appropriate people for the level of care that they need. We do not go out and solicit these people, although we have numerous and a modicum of numbers needing that type of care.

We cannot tell a family that their family member does not need to be there. You can imagine the things that would happen if we started doing that.

We are also, as Mr. Howe stated, in agreement as to the other levels of care that need to be out there for the elderly. I know for a fact that providers of long-term care in our association want those families to try every option available to them before they consider a long-term care facility. And I am saying that. Try everything within your means that you can.

As to patient rights Mr. Domrese mentioned, there is a State law that says, as a facility you must have patient rights. That is in every facility's policy statement.

And last, please, Mr. Domrese, don't tell me that I don't care about the people in my facility. You don't know me that well, but I invite you, an open invitation to my facility, at any time, and you and I will sit down and we will discuss how to improve patient care.

Senator **Burdick**. Just remember the time constraints, please. We want everybody to be heard.

STATEMENT OF ESTHER THOMSEN, UNDERWOOD, N. DAK.

Ms. **Thomsen**. Esther Thomsen from Underwood.

I don't know if my subject is exactly on nursing homes but I know it is on continuum of care and that is what we are talking about, isn't it?

Senator **Burdick**. Long-term care; right.

Ms. **Thomsen**. If the nutrition program is the beginning of long-term care, it is the social part, but it is important, and the busing program, and so on, and that is what we are concerned with right now in our particular case, but it is the funding. And I sort of go along with what Byron Knutson said. If this is a Federal program, and the grants come from the Federal program, and then they demand a matching fund, it is like pulling a rabbit out of a hat in these small areas. We just don't have that kind of money in the small areas, and this to me is an important program. I believe it should be funded by the Government without matching funds. Now, this is my pet peeve.

If you were on the committee of raising that money, you would know what I am talking about. It is just not out there in those small areas. I recommend to Senator Burdick that we appreciate the program and we don't want them to go down the drain, but we are just very afraid we might lose them this fall.

I would recommend very strongly, do away with those matching funds.

Mr. **Domrese**. I would like to back up the statement made by our former tax commissioner that our problem with the medical community is expansion. They have absolutely no regard for consumers. They build, they do, they get just what they want.

With regard to Keith Gendreau and his remarks concerning the 40 percent, he doesn't have to argue with me about that. The people he has to talk to are Dr. Reiff of the North Dakota School of Medicine, and many other internationally known geriatricians and gerontologists. I was quoting them. This is not my idea.

And also I would like to point out to you that one of the things we have been interested in in the State of North Dakota is the fact that most of the decisions made with respect to what is done to and for the elderly are made by people who are not. So what do we have? We have physicians making snap judgments as to who should be in a nursing home with scant knowledge of the social implications involved. We have the spectacle of the physicians and the nurses of North Dakota banning together and preventing those who were trained to do social work from becoming licensed and accredited in the State. We do not have social workers who are accredited because this is the block that is standing in the way.

Do you think that a doctor that is as busy as he is has the qualifications to be the sole determinant as to who is to go into a nursing home?

The social worker is the person who was trained to be involved in making these decisions and is prevented from doing so on an accredited basis. This must be corrected.

Thank you.

STATEMENT OF SCOTT BOEHM, BISMARCK, N. DAK.

Mr. **Boehm**. Senator Burdick, I am Scott Boehm, a medical social worker in Bismarck.

You touched earlier on some things that are being proposed in Washington that I would like to expand on a little bit.

Now, the Reagan administration is encouraging the financing administration to eliminate many of the regulations that have to do with nursing homes, Federal regulations. And this administration is trying to eliminate nursing homes to have social services provided to their patients and families, to also eliminate medical care evaluation, studies, and requirements for staff development in nursing homes.

Some of the other things that I think will have a serious effect upon the patients and families are that they also want to eliminate the requirement that there be a medical director overseeing patient care and employees' health within the nursing home.

There is a number of other services and safeguards that they are trying to eliminate, and I would like to have you at least resist some of these proposals in Washington and to carefully sift through those regulations that perhaps are no longer needed; but I think there is also some that are very important.

Thank you.

Mr. **Knutson**. The recommendation for developing a publicly financed health insurance system is made in the spirit of wanting to help both the health care providers and the consumers of health care services. Unless we succeed in developing such a system it seems to me we will be placing high quality health care services in great jeopardy. Why do I say this?

Costs for health and medical services are rising at a rate considerably higher than other consumer items. This then means that health insurance premiums will also continue to rise with the result that consumers will increasingly consider dropping their insurance or else reduce the benefits which means generally assuming a large deductible. Health care facilities will then find it necessary to make choices they haven't had to worry about for the past several years. We will be returning to the days prior to Blue Cross-Blue Shield when many could not qualify for health insurance and health care providers many times were not paid for the services. How long could a present day health care facility continue to operate without receiving payment for services? What kind of salaries would the employees in the health care field have if people couldn't pay their bills?

You may be certain that it is my wish that we develop the best health care delivery system in the world. We surely do have many competent, dedicated, and concerned people in the health care system and I think we all want them to be compensated at a reasonable level and given opportunities to serve in adequate facilities and with the help of the best technologies. It is clear to me that the best way to insure a healthy health care system is to develop a system of public health insurance and with a little more pride in our country we can develop that kind of a system.

STATEMENT OF KATHY DONLIN, BISMARCK, N. DAK.

Ms. DONLIN. I am a student nurse at Mary College. I just want to make one comment about two statements that were made earlier by this gentleman here [indicating] about the 40 to 60 percent of the people who should or should not be in nursing homes and then the response that was made by the gentleman back here [indicating].

I don't think whether they should be there or shouldn't be there is the issue we should be looking at. It is whether or not there are alternative choices. Those people may not have a choice, and because there is nothing available, that is the only place they have left. So they probably do belong there under the circumstances. But with an alternative choice for care, they probably wouldn't need to be there.

That's it.

Senator BURDICK. How many more have we got back up here?

VOICE. Two.

STATEMENT OF MAYSIL MALARD, BISMARCK, N. DAK.

Ms. MALARD. I am Maysil Malard, and I am from Bismarck. I was called and asked to make a prepared statement, but I'm going to send that to you later.[1] I just wanted to make a comment in regard to our nursing homes because there have been some things that have really bothered me here this afternoon.

I started a course in gerontological nursing back in 1970 through the Bismarck Hospital School of Nursing. I have had an opportunity to be in a number of nursing homes here in the Bismarck area, as well as throughout the State.

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[1] Not received at time of publication.

In regard to the comments that have been made related to cost, I believe it was brought out today that the cost of a nursing home today is $35.

Senator **Burdick**. It is $35 to $50.

Ms. **Malard**. I wonder how many hotel or motel rooms you can find for $35 to $50 per day. I attended a conference in Boston last September and my room was close to $90 just for a bed. When I think of the services that nursing home administrators have to provide people that are in nursing homes, I really question how they are able to do it. Skilled nursing care must be provided around the clock, 24 hours a day. They must provide occupational therapy, physical therapy, nutritional services under the supervision of a dietitian, to say nothing of the nursing service with all the support services.

I have oftentimes questioned in my own mind how in the world they are able to provide the services at the cost that they do.

I recognize that for an individual to have to pay these costs is tremendous and so I think we need some support in the area of assisting people to be able to keep them in nursing homes.

But when you think of the regulations there are things that they have to provide, I think that they are very, very careful with their dollars and how they are spent.

I also would just make a comment that I very strongly agree with alternative nursing care; and that we need to really reinforce these areas, because if people can stay within their own homes, it is a tremendous asset to them and enhances their feeling of their self-esteem and self-worth in being able to care for themselves and maintain the responsibility for their own care.

Thank you.

STATEMENT OF ARNOLD HOLDEN, BISMARCK, N. DAK.

Mr. **Holden**. My name is Arnold Holden. I live here in Bismarck. And what I wanted to talk a bit about is many people in North Dakota were not able to afford medical insurance. I just talked to a lady from Kidder County. She said the average income of a worker in Kidder County is about $400 a month. Well, that is bare living if you can live with that. And if they are going to pay Blue Cross $200 a month, they don't have anything else. So this is a problem.

The medical thing has gotten way out of whack, and there has to be something done for the people that can go to a doctor in the hospital. And I think that this has to be looked at, whether you have, you know, a government program, but it is certainly inadequate now.

We have a duplication here in Bismarck of a CAT scanner which is a waste. One hospital had a CAT scanner. It cost three-quarters of a million dollars. And there was another one put in the city and one is plenty.

I have talked to the doctor in charge of one and he said they could take care of everything in western North Dakota. So what will happen is people have to pay for those things and will have to have something done to control costs both in medical fees and hospital rates.

Senator **Burdick**. We have one more.

STATEMENT OF FRANCES FETTIG, BISMARCK, N. DAK.

Ms. **Fettig**. My name is Frances Fettig.

What I would like to bring up is they are complaining about the increase of the facilities the hospitals are billing and if we didn't have those facilities, the people would complain, too, so I don't know who you are going to listen to, the ones that want more facilities or—like I said, every time they get something new, it costs somebody something.

Well, if we didn't have those facilities, people would complain, too. That is all I have to say.

Senator **Burdick**. Well, I think that completes the public portion of it. I want to thank all of the panelists and all of the witnesses for helping make this record. If you have any written statements, I hope that you will submit them to me within the next 2 or 3 weeks. You can mail them to me at my office in Washington.

So with that, the hearing will be adjourned.

[Whereupon, at 4:10 p.m., the hearing adjourned.]

APPENDIXES

Appendix 1

BACKGROUND INFORMATION ON HEARING[1]

PURPOSE OF THE HEARING

Major changes in Federal policy toward long-term care offer both problems and opportunities to State and local health care providers. Last year, significant Federal budget cuts were made in the medicaid program (the single largest source of public payment for long-term care services) and additional reductions have been proposed for next year in both medicare and medicaid. These reductions will directly affect the development of both nursing home and community long-term care services. At the same time, Federal policy changes have been made to encourage a greater reliance on home care within the medicaid program. A major policy debate has also been taking place regarding the appropriate role for the Federal Government in safeguarding the rights of those elderly who reside in institutions.

The hearing will focus on the probable impact of several Federal proposals on the development of North Dakota's long-term care policy, and explore alternative future directions for developing cost-effective long-term care programs. The committee believes that North Dakota will offer a unique perspective because of its rural nature. Of special interest will be the experience with hospital "swing bed" programs, which offer promise as a cost-effective way of increasing nursing home bed availability in rural areas, and plans in Burleigh County to increase emphasis on "optional" medicaid community and home-based services.

WHAT IS LONG-TERM CARE?

The phrase "long-term care" is increasingly being used to refer to a full spectrum of services needed by elderly Americans to help them cope with chronic long-term illness and physical disability. Those who can no longer remain completely independent and need some assistance with normal activities of daily living can be considered part of the population in need of long-term care services. Services which may be needed depend on the degree of disability and range from hospital and nursing home care to intermittent community services such as nurse, home health aide and homemaker visits in the home, home-delivered and congregate meals, transportation, and other social supports.

WHO PROVIDES LONG-TERM CARE?

Many of these services are made available through public programs, but the bulk of care provided to those who can still remain at home is still provided by family and friends of those who need assistance. (Nationwide, from 70 to 80 percent of all support provided to the elderly is given by family and friends.) Public agencies providing long-term care include hospitals, nursing homes, home health and homemaker agencies, and senior centers.

WHO PAYS FOR LONG-TERM CARE?

The cost of nursing home services for the elderly is the single fastest growing component of total national health expenditures. The total bill (nationwide) for nursing home services was $17.8 billion in 1979, $24 billion in 1981, and will reach at least $76 billion in 1990. About one-half of the total cost of nursing home care for the elderly is paid for directly by the elderly themselves, or their families.

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[1] Prepared by the staff, U.S. Senate Special Committee on Aging.

Medicare, the Federal health insurance program for the elderly, pays for a very small part of this bill, only about 3 percent. Requirements for a relatively high level of skilled care, including prior hospitalization, and restrictions on the number of days covered (100) serve to keep the medicare contribution at this low level.

Medicaid, a shared Federal/State health insurance program for low-income individuals, pays for about 50 percent of the total nursing home bill for the elderly. Since this source of payment is available only to those with small income and/or assets, however, many elderly who enter nursing homes are not eligible for this assistance. On the other hand, the costs of nursing home care are high enough (average annual cost of about $17,000) that many patients who enter nursing homes use up what resources they have within a short period of time and subsequently become eligible for medicaid payments for their care.

A variety of home care services are available through combinations of Federal, State, and local public programs. Medicare has a home health benefit which pays for skilled nursing and related therapy services on an intermittent basis in the home. The availability of medicare home health services has expanded significantly in recent years, but it also represents a minor portion of total medicare expenditures (under 2 percent). In general, home health services certified for medicare payment are much less likely to be readily available for elderly patients in rural areas than they are in urban areas where there are higher concentrations of elderly.

The Federal/State medicaid health insurance program also can pay for home health services for low-income elderly. The Federal law was recently changed to encourage States to devote a larger share of their medicaid programs to home care services for the elderly. The new law was meant to give States more flexibility to cover a broader range of home care services under medicaid, including homemaker, day care, and "respite" services. A special demonstration program is now underway in Burleigh County to explore the feasibility of increased medicaid coverage of these "optional" home care services in North Dakota.

Other sources of funding for home care and community services are through social services funding (primarily homemaker services) and through aging services offices. Federal and State funds administered through the aging services office can be used for homemaker and chore services in the home, day care, senior center services, meals-on-wheels and congregate nutrition programs, and transportation programs for the elderly.

CURRENT TRENDS

All of these public responses to the long-term care needs of the elderly have expanded significantly in recent years, primarily in recognition of the rapidly growing elderly population. Increasing attention is now being given to the development of a broad spectrum of home and community-based services to broaden a "continuum" of long-term care from a primary reliance on nursing homes to a full range of services suited to different levels of need. This movement has been encouraged by a number of factors, but two stand out:

(1) Escalating health care costs are making the purchase of nursing home care an impossible burden for more and more older Americans. These high costs, coupled with the coming population explosion among those who will be in need of long-term care, have also convinced many experts that public budgets will not be able to sustain future long-term costs unless more emphasis is put on ways to find less costly forms of long-term care services.

(2) The elderly themselves consistently express a preference for community services and home care as a way to avoid or delay nursing home placement.

GROWTH OF THE U.S. ELDERLY POPULATION

There are now (1980) 23,743,000 persons aged 65 and over in the United States—11 percent of the total population. About 37 percent of all elderly live in rural areas.

By the year 2000, the Nation's elderly population is expected to reach 32 million—over 12 percent of the total population.

NORTH DAKOTA'S ELDERLY POPULATION

In 1970, North Dakota's elderly (age 65 and over) numbered 66,000, 10.7 percent of the State's total population.

In 1979, there were 80,000 North Dakotans age 65 and over, 12.1 percent of the total population.

Between 1960 and 1979, North Dakota's elderly population increased by almost 36 percent.

THE POPULATION IN NEED OF LONG-TERM CARE

The elderly are 4½ times more likely to suffer activity limitation than those under the age of 65. The percentage of elderly who are unable to carry out major activities of daily living (such as bathing, eating, dressing) increases from 14.4 percent among those 65 to 74 years old to 32.9 percent of those age 85 and older.

About 17 percent of those over the age of 65 are unable to carry out major activities. The percentage of the total elderly population residing in nursing homes increases dramatically with age, from 1.4 percent for those in the 65 to 74 age group to more than 20 percent for those age 85 and over, 90 percent of the people in nursing homes are over 65.

Between 1980 and 2030, the total population is expected to grow by 40 percent, but the elderly population will more than double. And the population over 85, precisely the group most likely to need long-term care and most at risk for institutionalization, will almost triple. Without change in current nursing home utilization rates, the number of nursing home residents will increase 54 percent over the next 20 years, and 132 percent (from 1.8 to almost 3 million) by 2030.

PENDING LONG-TERM CARE INITIATIVES

(1) S. 234, a bill to expand medicare and medicaid coverage for home health services. If enacted, the bill would allow coverage of homemaker and home health aide services for those elderly who would otherwise have to be placed in a nursing home. This bill would also authorize grants through the Public Health Service to provide for initial startup of home health agencies in areas which are not now served, particularly in rural areas.

(2) S. 1754, a bill which would remove the current medicare requirement that a patient be hospitalized for a period of at least 3 days before becoming eligible for the medicare nursing home benefit. Many have testified previously that patients are frequently placed in a hospital by their physician solely for the reason of establishing eligibility for the nursing home benefit, unnecessarily adding costs to the medicare program. A similar requirement for establishing eligibility for the medicare home health benefit was removed from the law during the last Congress.

(3) S. 1958, a bill to provide a medicare hospice benefit as an alternative to hospitalization for terminally ill elderly patients.

(4) Work is being done on a bill to provide an income tax credit for families who are caring for an elderly relative in their home. This initiative is meant to provide support for family members who might not otherwise be able to keep elderly relatives at home.

(5) Additional legislation is also being developed by members of the Committee on Aging to authorize supportive services, such as meals and homemaker services, in special housing arrangements for the elderly and to encourage shared housing arrangements among the elderly.

Appendix 2

LETTERS FROM INDIVIDUALS AND ORGANIZATIONS

ITEM 1. LETTER FROM WAYNE L. HANSEN, ADMINISTRATOR, BETHEL LUTHERAN HOME, WILLISTON, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED MARCH 31, 1982

DEAR SENATOR BURDICK: I would like to thank you for your interest and concern you are giving to the aged in our county and our State. Our State of North Dakota is very different from the Nation because most homes serving the elderly are nonprofit or community owned. The people of North Dakota have provided and continue to meet the needs of their fellow man through their support and willingness to give up some of their personal needs to share with others. Our history proves this.

Now we have had much Federal support these last years in creating senior citizen centers that provide meals-on-wheels, congregate meals, transportation to the centers, shopping, medical, and social events. The home health and homemaker aides that are available through social services also help those individuals who cannot get out of their homes on a regular basis.

We, here in Williston, have seen all these things begin and continue to expand the services to the handicapped and elderly of our area these past 8 years.

Since these (out of the institution) services have become a reality, the Bethel Home has been able to continue to meet the total needs of our area's population, without adding beds, even though the aging population has grown. We even have a few empty beds available and no waiting list. This is very different from the many years of long waiting lists and long periods of time for the aged people to wait until a bed was available.

I feel the availability of beds in our facility is directly related to the excellent (out of facility) programs that are available in Williston.

I can see the future out-of-the-facility services expanding or caring for greater numbers of people who require these types of services and when our local units can no longer meet all these needs, the Bethel Home will then implement these same programs to help supplement the needs of our area services to insure all services are provided to all.

I have always thought a day care for the very incapacitated person who is being cared for in their own home would be of great benefit to supplement the person who is taking care of the handicapped relative at home. We have this program available. We will go to a home, pick up a person in the morning, bring them to the institution, provide all medical, therapy, and activity needs for the day, then take them home for the night or keep them 1 night if there is a special event the family wanted to attend. Doesn't this program sound as if it would help many people stay in their own homes longer and eliminate the need for the utilization of a skilled nursing home bed? Wrong, we have made this available the last year and no one has ever used the program. From this trial program, I can only deduce that people who are receiving skilled nursing care in our area are being very adequately cared for in their own homes, or all people who require skilled nursing care are already in a skilled nursing home.

We are continually looking into programs of services to the aging in our area and feel we do have excellent and adequate programs at the present time. To keep our area meeting these needs, the Bethel Home is willing and prepared to expand our staffing and services into the community when it is needed.

There will be fewer persons who require institutionalization if we can keep the good community supplemental programs available. This will eliminate the need for the costly building of additional long-term care beds.

We have our certificate of need to build a new activity room, put our chapel area into the present activity room, and the old chapel area will be available for the day care or staff areas for meeting the new out of facility services when the need arises.

We also will be building the foundation of the new activity room to accommodate four additional floors. This will help us utilize the full potential of our land space in the future and also the multistory has so much advantage for energy conservation in our cold climate.

The plans for four very nice two-bedroom apartments for the elderly on each floor above the new activity room are being studied. We would not utilize any Federal funding, but will try to have the people fund the apartments with a guarantee all the services of Bethel Home would be available at cost to these people when or if they may need services. This would be like a life estate and the apartment would belong to Bethel Home and would be used for serving others in the future.

Thank you for listening to my thoughts on our local aging services.

Sincerely,

WAYNE L. HANSEN, *Administrator*.

ITEM 2. LETTER FROM GARY M. RIFFE, FACNHA, ADMINISTRATOR, HI-ACRES MANOR NURSING CENTER, JAMESTOWN, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED MARCH 31, 1982

DEAR SENATOR BURDICK: I received your March 25, 1982, letter this morning in regard to your hearing in Bismarck. Since that is an election day here in Jamestown, I would like to take the opportunity of sending you my thoughts in a letter so that you can devote more time to those individuals who come to the hearing.

I am sure that some of my concerns and needs that involve residents at Hi-Acres Manor and the future of our profession will also be represented at your hearing in Bismarck by Allen Engen of the North Dakota Health Care Association.

Yes, we agree that the long-term care is going to be a major issue for the elderly in the coming decade. We also know that there is going to be a large growth of persons in the 75 to 85 age group within the next 10 years. Of that group, we have no way of knowing how many are going to need the services of long-term care. We feel that long-term care is a very viable and important segment of the health delivery system and we are proud to be able to provide this much needed service to the residents in our community and surrounding area. As you know Hi-Acres Manor has been providing this type of care and service since 1962 and we have continually upgraded our facilities and services to meet the needs of the residents in the coming years.

I would like to speak a moment in regard to regulations. We are probably one of the most regulated industries in the world. Of course we have brought this on ourselves because we did not do our own peer review way back when. But many of us today who have been in the field for the last 10 years have realized that some regulations are good and they have helped in the improvement of care. Our concern is being able to streamline the different agencies where one agency could come and give us that inspection, or review, or whatever you want to call it, to show the public we are providing quality care in safe surroundings at reasonable costs. Whether it is the State Health Department within our own local State or if it is joint commissions on accreditation for hospitals and long-term care, or whatever. This would be better than having State, Federal, and social services and whomever else of late that is making their inspections. We are hoping here in North Dakota that by showing that we can give quality care, the Department of Health can now issue a 2-year license. Many of the homes are qualifying for this. This is a goal that we are shooting for at Hi-Acres. Our only concern is that if regulations are dropped too drastically and there is no one to check, the industry as a whole could have some problems. We know we have facilities that are having difficulties complying with regulations now. What would they do without some mechanism of assuring the public that the facilities are providing quality service.

In regard to the empty hospital bed project that has been sponsored by the North Dakota Hospital Association. At least in the Jamestown area this has not had an effect on us at this time because the needs of the people who need skilled care can receive it in the two long-term care facilities that are here in Jamestown. But this does not take into account some of the smaller communities who have small hospitals who wish to participate in the swing bed so they can help their census. There needs to be some mechanism that assures the public and the nursing homes that the hospital will not abuse the swing bed program.

As far as other alternatives, our feeling is there is no alternative for skilled care. This needs to be put in the media and each time we visit with groups of aging population, that there is no alternative for skilled care. A person who needs skilled care needs it on a 24-hour-a-day basis by professional people and you can not have that in any other type of surrounding at a reasonable cost other than in a quality nursing home. We know that home health gets a lot of publicity of late because they can provide some skills but they can not do it on a daily basis, or 24 hours a day at reasonable cost. I am sure that you have been given studies in regard to this matter which has home health versus the long-term care facility. Our research locally as well as nationally shows that home health on a per day basis is much more expensive than long-term care is. Yes, we strive within our own facility to encourage that resident who comes to us to reach the maximum rehabilitation level that they can achieve. If, for example, it is a stroke patient who comes in for rehabilitation and they are taught to walk, how to eat, how to talk, and can go back to their own home or into a sheltered environment, we encourage this. Our records have proven over the past few years that over 50 percent of our population at Hi-Acres Manor either go home or go to a lesser care facility. We are very proud of this because we feel that we are achieving what long-term care is all about. We also know that many of the residents who stay in a long-term care facility are there many times because they want to be. They like the protection, the security of knowing that someone is there on a 24-hour-a-day basis to provide them with their basic needs. So those residents who wish to go home or wish to go to a sheltered facility or a foster home are encouraged to do so. Those who wish to stay are encouraged and a care plan is given.

I don't know whether or not you are aware of it, but most of the nursing homes, at least in the State of North Dakota—and you should be proud of this—provide a care plan on each resident as they enter the facility. This is reviewed on a monthly basis for the first 90 days and then on a quarterly basis for the remainder of time they are residents in the facility. We have found this to be a positive approach to the health delivery system within our facility. We try to encourage and involve families in this program and families have been very surprised when they find the types of care, the types of services that their family members receive in a long-term care facility. So our thoughts and feelings at this point are not to totally wipe out the long-term care facility. Continue to support us by providing dollars to take care of those needy residents who cannot provide for themselves. Allow us to expand services if they are needed and justifiable and also allow us to be able to get a good return on our investments. Through the reimbursement mechanism in most States, and North Dakota is no different, the reimbursement mechanism leaves a lot to be desired. It does not encourage individuals to buy facilities because there is no incentive and no way to get a decent reimbursement rate. In most instances we can get better rates out of passbook savings with our dollars than by providing long-term care. Of course this brings up the age-old issue of whether health care should be provided by nonprofit agencies or taxpaying agencies.

I think the record proves across the United States that long-term care can and is provided in quality and services for less dollars in taxpaying entities than in the tax-exempt entities. It is not always the case but in most instances the taxpaying or as the public calls it the "for profit programs" do provide a much higher quality for less dollars and in safe surroundings.

The last area I would like to mention is the area of subsidized housing for the elderly. Jamestown as a community has been very aggressive in the area of providing low cost or subsidized housing for its citizens and at this point the information that I have received is that the Jamestown area cannot receive any more Federal dollars either for a HUD-subsidized housing project or FHA-assisted programs because we already have more than adequate for our population. We feel in the community that this is not so. Jamestown is a community of older citizens and yet it has a good base of younger people in which to carry on the businesses that are already here. We have had our application in for some subsidized apartments with the FHA since 1978 and at this point have not even been given the courtesy of telling us where we stand. We know that many dollars have been cut out of the program on a national level and we know why. At this point there is not much building going on, but you need to know that we should look at some type of housing that would allow residents to live as independently as possible, at a rate their rent can be subsidized so that they can have something nice to live in. We know that many of the residents have very adequate homes at this time but there are some who do not. We feel there is still a need in our Jamestown, Stutsman County area. We would be very excited to be able to participate in a program in which we could add some apartments of self-care into the complex that we presently have and make a complete retirement and long-term care community in close vicinity of the nursing home. They are very compatible as you have probably noticed and seen throughout the country and the State of North Dakota. A self-care apartment has worked out very adequately many times when a resident has a spouse in a long-term care facility and the wife or husband wishes to live close by in an apartment. This allows the resident to go visit with their spouse at the apartment for overnight stays or for just the day. This has really been a successful part of their care plan.

I thank you for being able to have these hearings throughout the State and I know that you will receive a lot of information that is very valuable to you and we know that being on this Special Committee on Aging is very important.

I hope that our thoughts and comments will be helpful to you and your committee. If you are ever in the Jamestown area we would be more than honored to have you come and visit the residents in our facility.

Best regards.

Sincerely yours,

GARY M. RIFFE, FACNHA, *Administrator.*

ITEM 3. LETTER FROM TONY C. HANSON, ADMINISTRATOR, SUNSET HOME, BOWMAN, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED MARCH 31, 1982

DEAR SENATOR BURDICK: Thank you for your letter informing me about your hearing, emphasizing the "Future of Long-Term Care." I regret to say that I will not be able to attend this hearing but I do have some thoughts on the subject.

We do have some challenging months as well as years ahead of us in the field of long-term care. The Sunset Home, at present, has an average resident age of 80 years old. I am also projecting that this will increase as health care changes. I feel that we are offering our service area of the 65 and older population all possible alternatives to long-term care placement. Services available at present are: Meals-on-wheels, homemaker service, home health aide service, low-income elderly subsidized housing, nonsubsidized elderly housing, Public Health nursing, and our community hospital is active in the swing bed concept due to the high occupancy rate at our home. Some future services to our elderly population include: Adult day care plus an additional 20 intermediate care facility beds at the Sunset Home, and a nutritious meal will be offered to all senior citizens in Rhame, Scranton, and Bowman.

As an administrator, I don't feel that we have taken in any residents that do not belong in a licensed care facility. With your projected statistics as well as ours, long-term care facilities are going to change. The result possibly will be more "skilled residents" but I don't think that we will lessen the amount entering a long-term care facility.

I also hope that you continue to watch this problem area and when needed, consult with providers in the field of aging.

Sincerely yours,

TONY C. HANSON, *Administrator.*

ITEM 4. LETTER FROM THOMAS A. O'BRIEN, HAMPDEN, N. DAK., VICE PRESIDENT, NORTH DAKOTA SENIORS UNITED, TO SENATOR QUENTIN N. BURDICK, DATED MARCH 31, 1982

DEAR SENATOR BURDICK: It will not be possible for me to attend the Aging Committee field hearing at Bismarck April 6. But I am very much interested in the future of health care for the elderly. Any programs that help to keep older people active and out of nursing homes for a longer period of time are very worthwhile. Home health care might be rather expensive to administer but if it helps to accomplish that it is very worthwhile.

Sometimes just getting older people to eat the proper food and take some exercise will accomplish an awful lot. Possibly some existing programs could be combined? I wish to present this as my testimony on this subject.

Thomas O'Brien.

ITEM 5. LETTER FROM KATHY SCHUMAN, R.N., DIRECTOR, HOME HEALTH AGENCY, OAKES COMMUNITY HOSPITAL, OAKES, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 2, 1982

Senator Burdick and Members of This Committee: As director of the home health agency at the Oakes Community Hospital in Oakes, N. Dak., I am addressing you through this written testimony.

Our Home Health Agency serves Dickey, La Moure, and Sargent Counties. There is a part-time public health nurse in Sargent County but no other agency to care for people in their homes except county social services who have homemaker services.

In the three-county area, we have three resident physicians and two hospitals with approximately 55 total beds. Health care is at a great distance and frequently extremely difficult to obtain for the elderly who have ambulation problems. Our agency employs seven contract nurses who cover the entire area.

Approximately 25 percent of the three-county residents are over 65 years. Yearly, the percentages rise. These people wish to remain independent and stay in their own homes or apartment complexes for the elderly. After a hospitalization, home health may visit until their condition is stable for 21 days. Then medicare will no longer reimburse for visits to monitor these people, keep them healthy, prevent costly rehospitalization, and possibly nursing home placement.

This is not to say that placement in an ICF or SNF can always be substituted or delayed by home health care. Many elderly cannot live safely at home. It is my experience though, that I recommend nursing home care and assist in placement from home health to an ICF or SNF far more often than we receive a patient that has been discharged from a nursing home.

I feel the elderly of my area need an observation and prevention program that can monitor those people who are homebound but do not meet medicare criteria for care. You may say to that, "What about homemaker services?" In the past few months, I have made various referrals to the social service agencies in my area. I felt these patients needed continued observation that I couldn't give under medicare. These referrals have been refused because of lack of funds and manpower.

If an agency or department, be that Federal or State, could include the prevention services in our home health program, many hospitalizations and nursing home placements could be prevented. These people could stay in their homes, continue to be a viable part of the community, with the assistance of possibly meals-on-wheels program, weekly prevention and observation visits made by competent trained personnel to assist with medications and other medical necessities.

The cost of a minimal observation and prevention program to set up medications and check vital signs has to be considerably less than ICF or SNF costs. The end result is a happy and content elderly person, dignity intact and in his own home until that time when physical, emotional, or environmental problems demand higher level of care.

I feel the home health agencies in the State of North Dakota can provide this service competently and at a savings to the taxpayers.

Respectfully submitted.

Kathy Schuman, R.N., ***Director.***

ITEM 6. LETTER FROM DORIS A. FISCHER, R.N., DIRECTOR, BISMARCK CITY NURSING SERVICE, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 5, 1982

Dear Senator Burdick: Bismarck City Nursing Service is very distressed over the possible cutback of Federal funding for our senior citizens.

This action would result in the curtailing of many of our services to the elderly.

At the present time we have six staff nurses, each providing home care in a designated area of the city. The reduction in funds would result in the loss of one or two nurses. This would have adverse effects on both the quality and quantity of care each nurse could provide, because her time and talents would be spread very thin.

In the past we had provided nursing services and maintenance clinics, 2 to 3 days per week, to the elderly at Crescent Manor in Bismarck. Because of funding cuts we had to reduce those services to an "on call" basis. The nurse is called in only for emergencies.

The maintenance clinics provided preventative services, in an attempt to keep the elderly out of the nursing home and hospitals. With the cuts already made and possible future cuts, it will not be possible to meet the preventative health needs for the elderly.

Because we as Public Health nurses must deal with the complete physical, mental, spiritual, and social well-being of the senior citizens, with funding cuts we feel we will no longer be able to provide these services and there will, therefore, be more hospital and nursing home admissions for our elderly.

Hospitals have not been able to discharge the elderly to their own homes, when they are well enough, because they are too fragile to care for themselves. This has resulted in costly, unnecessary expenditure of tax dollars to maintain these patients in hospitals and/or nursing homes.

With more funding for public health, services could be provided in the home, effecting earlier hospital discharge and, in many cases, more rapid recuperation for the patient.

Programs preventing illness and improving health care in the home will save our taxpayers dollars, not only now but in the future.

Sincerely,

Doris Fischer, R.N., *Director.*

ITEM 7. LETTER FROM BESSIE M. NORHEIM, PRESIDENT, TOWNER COUNTY COUNCIL, ROCK LAKE, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 5, 1982

Dear Senator Burdick: In reply to your letter concerning the care of the elderly according to statistics in your letter, we should be concerned with the construction of the type of housing where these people could remain semi-independent, where they could have private sitting rooms, bedrooms and bathrooms, and all food be prepared in a common kitchen, this could be much less costly than the rest homes for those who remain ambulatory.

Medicare has been most helpful and adequate to the elderly. We have the best and most sophisticated health care in the world. I have traveled in many countries, towns of 35,000 to 40,000 do not even have X-ray equipment in the British Isles. In Norway you must have the permission and proper papers from a nurse before a doctor will see you.

Bessie Norheim.

ITEM 8. LETTER FROM JANEL JACKSON, PARALEGAL, LEGAL ASSISTANCE OF NORTH DAKOTA, INC., MINOT, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 12, 1982

Dear Senator Burdick: Ms. Catalano forwarded your letter to us regarding your second Aging Committee field hearing in Bismarck on April 6. Since I was unable to attend, your opportunity to accept written testimony is appreciated.

From my personal contact with the elderly, the major concerns expressed are the high cost of medical care and the availability of medical support services. In such a rural State as North Dakota, an individual is limited in the medical services in their area. The elderly then are also faced with transportation costs to obtain the care needed. I think the elderly wish to remain as independent and self-sufficient in their own homes as long as possible. Without community-based services, such as homemaker, delivered meals, visiting nurses, etc.; the elderly are forced into institutionalization and possibly inappropriate placements in our nursing homes. I think financial efforts should be made to encourage the growth of these community-based programs. This will not eliminate the need for nursing home beds as that care is also necessary, but it will allow individuals to remain in their least restrictive living arrangement and the cost would be less expensive.

It is my understanding major changes in the Federal long-term care policies is proposed. At this time I do not believe there should be a slackening in their guidelines. Comprehensive guidelines on fire, safety, diet, professional staff qualifications, and monitoring of level of care should be closely scrutinized. Although it may be speculated, care will not change without the policies to monitor these facilities, there will be no safeguards for these residents.

Besides the high costs of skilled and nursing care, the high costs of health care in general has put a financial burden on the medicare and medicaid programs. The proposed cuts though put the burden on people already on a fixed income. It is quite disheartening for these people to continue to pay larger premiums and deductibles for medicare and yet receive less coverage. An individual recently contacted me about her hospital bill. Although the actual hospital charges were paid, medicare paid less than 50 percent of the actual charges of the physicians. Hundreds and thousands of dollars is then still the responsibility of this person. There is an appeal process regarding part B of medicare regarding the allowable charges but the hearing officer is an employee of social security and the impartiality of this hearing officer is questionable.

At this time the medicaid program in North Dakota is providing more comprehensive coverage compared to other States. The Omnibus Reconciliation Act has lifted most requirements of this program and an individual State could totally revamp their services and eligibility. At this time North Dakota has not proposed any changes in their medical assistance program but if Federal money is eliminated on optional services, the State may be forced to eliminate services. It is hoped the North Dakota Legislature will continue to feel an obligation to the people to keep the current level of services. Any proposal such as copayment or lowering eligibility will again be detrimental only to the people already struggling. Another of my concerns is that if the medicaid program is managed federally that restrictive financial guidelines and a minimum of services will be imposed on the States. This would definitely affect many people who are already medicaid recipients.

It is hoped you will take my observations into consideration. Again thank you for this opportunity to comment.

Sincerely,

Janel Jackson, *Paralegal.*

ITEM 9. LETTER FROM JANE M. CROEKER, PARALEGAL, LEGAL ASSISTANCE OF NORTH DAKOTA, INC., FARGO, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 13, 1982

Dear Senator Burdick: I am greatly encouraged by your interest and concern for North Dakota's elderly population. As an elderly law paralegal, I appreciate the opportunity you are extending to senior citizens and their advocates.

Older people across the State are sending a plea for independence by strongly advocating for community care alternatives and improvements in the medicare-medicaid programs. Gaps existing in these programs penalize the vulnerable and lead to inappropriate nursing home placements. Proposed budget cuts and restrictive regulations will further erode the medicare and medicaid programs, which are inadequate in their present form.

Sizable increases in premiums and deductibles have been made in the medicare program. Older Americans are being asked to pay more for less health care coverage at a time when inflation has dramatically reduced their buying power. Implementation of increases in medicaid premiums and deductibles as well as Reagan's medicaid copayment proposal are economic and social folly.

Expansion, rather than reduction, of the medicare program to include coverage of maintenance costs, preventive care costs, and actual charges would significantly reduce nursing home placements. Inadequate income to obtain medical care and meet necessary living expenses escalate impairments to a crisis level forcing premature institutionalization. These placements constitute a severe violation of individual rights and create an unnecessary depletion of public and private funds.

Elderly people are being denied their due process rights in the medicare part B appeals process as well. Those who express displeasure regarding an intermediaries decision encounter Blue Cross-Blue Shield employees who misinform them and discourage them from pursuing an appeal. To compound these problems, the appeals referee is an employee of the carrier, making impartiality impossible. Even though many senior citizens voice disagreement with medicare decisions, few overcome obstacles to pursue a grievance. Those that do surmount the obvious barriers are confronted with roadblocks established by the intermediary.

Representatives who are truly concerned about the needs of older Americans will work toward expansion and improvement of existing programs, rather than counterproductive proposals for further restrictions.

Sincerely,

JANE M. CROEKER, *Paralegal.*

ITEM 10. LETTER FROM KARLA R. SPITZER, IMPLEMENTATION ASSOCIATE, DIVISION OF HEALTH PLANNING, STATE CAPITOL-JUDICIAL WING, NORTH DAKOTA STATE DEPARTMENT OF HEALTH, BISMARCK, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 21, 1982

DEAR SENATOR BURDICK: Thank you for your letter of March 25, 1982, and the opportunity to present testimony to the Senate Aging Committee.

The Department of Health's position on long-term care is that there needs to be an appropriate balance between noninstitutional and institutional services for the elderly. This need is even more urgent and attractive given the present national momentum and shifting of financial responsibilities involving the State and the individual. While we are not prepared to elaborate on the appropriate mix of institutional and noninstitutional services at this time, we are in the process of assessing the availability and access to such services in North Dakota. This project is being done with the cooperation of the Office of Aging Services. The objectives of the project are: (1) To develop a usable definition of "continuum of care" for the elderly which includes institutional and noninstitutional care; (2) to identify all existing services for the elderly or lack of services on a per county basis in terms of the above definition; (3) to set an informational base that can be used to make legislative and programmatic decisions in the area of resource allocation, financing and reimbursement; and (4) to make the inventory available to other agencies and to the public.

We recognize the need for long-term care facilities. They are essential for a significant number of people. However, we also recognize that there is not a comprehensive range of preinstitutional and postinstitutional services. In dealing with services for the elderly, we often collectively rely too heavily on institutional arrangements for care and underemphasize and seldom exhaust other potential options.

One means of addressing this issue would include a redefinition of "long-term care" to include:

—An emphasis on wellness and prevention.

—An emphasis on maintaining individuals in their homes and communities as long as possible through the aid of in-home help and other services.

—An emphasis on better information and better coordination of existing health and human service programs.

—An emphasis on careful delineations of appropriate use and levels of care, such that each individual is maintained for as long as possible at an optimum level of physical health and mental well-being.

—Assistance and training or education for families and other informal care givers who already are providing much care for older relatives and friends.

—The need for ongoing education on the aging process so that older people and those who work with older people have factual information on the biological, psychological, and socioeconomic aspects.

—The need for case management or a single or minimum number of people assisting the older person to obtain appropriate services.

Some of this thrust can be accomplished through the present network of fine institutions already in North Dakota. Some of the thrust however, can only be accomplished through a comprehensive reevaluation of national and State policies and the financing mechanism that supports the present system.

Such an evaluation would remove the concept of long-term care from a strict facilities approach, and if judged appropriate, would enable reimbursement patterns to include, to a greater extent, the aforementioned services. Although at present, no comprehensive longitudinal studies have been done to study the cost benefits of preventive care and other alternative maintenance services, the implications are that these alternatives may prove to be more cost-effective than institutional care.

Again, we recognize a need for long-term care facilities, but we also recognize a need for a balance in services. In some parts of the State that balance is already there, but in other parts of our State, few services are available and the option is institutional care or no care at all.

One other issue to be considered is the lack of coordination of services for the elderly. Greater coordination of services, as facilitated through a clearinghouse function, would aid in the development of a situation more nearly approximating a continuum of care.

Sincerely,

KARLA R. SPITZER,
Implementation Associate.

ITEM 11. LETTER FROM SYLVIA HANSEN, SOCIAL WORKER II, TRAILL COUNTY SOCIAL SERVICE BOARD, HILLSBORO, N. DAK., TO SENATOR QUENTIN N. BURDICK, DATED APRIL 21, 1982

DEAR SENATOR BURDICK: I am happy that I was able to attend your November Aging Committee field hearing at Grand Forks and did submit some testimony at that time. I was unable to attend the one in Bismarck on Tuesday, April 6, 1982. but would again like to submit some testimony.

I feel that your concern about long-term care for the elderly is certainly most appropriate at this time. Fifteen years ago when I began employment in Traill County as a social worker about the only long-term care available to the elderly was skilled nursing home care. Along with this there was, however, a small amount of in-home health care from a public health nurse.

Since that time I have seen that services to the elderly grow to include homemaker and home health aide services, more public health home nursing service, senior citizen centers, congregate and home-delivered meals services, volunteer transportation and friendly visitor programs, senior employment programs, and senior citizen housing units.

Within the last 5 years, however, I have seen numerous of these services discontinued due to lack of funding and the remaining ones being threatened with the same end. Volunteer friendly visitor and transportation programs have been discontinued, homemaker and home health aide services have been curtailed and there has been a constant threat to be discontinued totally. The senior citizen center and meal services are currently under threat of curtailment.

Our census figure shows that our elderly population is growing at a fast rate and we can expect this to continue in the upcoming years. I have been involved in all of the programs serving the aged over the past years and currently am the most involved with the homemaker/home health aide program which I supervise on a county level. I would like to submit the following information to you for your consideration.

As of January 1, 1982, we had 54 family units receiving homemaker/home health aide service. Of those family units 6 contained at least one individual in the above 90 age range, 22 family units included at least one member in the 80 to 90 age range, 19 families contained at least one member in the 70 to 79 group, 3 families contained at least one member in the 60 to 69 age range, 1 family contained a disabled member in the 50 to 59 age range, 1 family contained a disabled individual in the 40 to 49 age range and 2 families contained children under the age of 18 who received this service as a protection service.

As you can see the majority of our recipients are the elderly, most of whom would be unable to remain in their homes if they were unable to receive homemaker/home health aide services. If, in fact, all these people were to enter institutional care the increased cost for care would be astronomical if they could even receive such care. Being realistic we can see that this large number of people would be unable to enter institutional care in our communities at any one time as there would not be vacancies in the institutional care settings to care for them.

I see it as being extremely important that we increase services for home care, nutrition, recreation, and mental health for the aged population, thus, enable them to remain in their independent living situations. This allows them to live out their later years in dignity and near independence while it is also at a much less cost to the taxpayers of the United States.

Sincerely,

SYLVIA HANSEN,
Social Worker II.

ITEM 12. LETTER FROM PRISCILLA EBERSOLE, FIELD DIRECTOR, MOUNTAIN STATES HEALTH CORP., BOISE, IDAHO, TO SENATOR QUENTIN N. BURDICK, DATED APRIL 28, 1982

DEAR SENATOR BURDICK: The Rural Health Services Act (Public Law 95–210) of December 13, 1977, has had far reaching effects in bringing badly needed health services to the geographically underserved. Nurse practitioners have proven their accessibility, cost-effectiveness, and positive impact on the quality of care in a recent study contracted by HCFA to System Sciences, Inc., of Bethesda, Md.

Given the professional credibility and public acceptance of nurse practitioners in the management of common acute and chronic health problems, it is timely to consider expanding the existing law to include those who are medically underserved due to their age.

Justification of use of GNP's:

(1) Institutionalized aged are underserved by physicians because they are poorly trained and disinterested in the management of chronic, long-term health problems.

(2) Routine visits to patients in long-term care are unnecessary and costly. Appropriate management of health care by qualified geriatric nurse practitioners would improve consistency and quality of care; effectively manage 90 percent of the health problems occurring in long-term patients. Physicians visits would be solicited when necessary and their time would be used wisely and effectively.

(3) Patients respond positively to the contact and availability of a GNP. Families feel assured that health care will be prompt and consistent.

(4) Geriatric nurse practitioners working with physicians and collaborating with other professionals can provide comprehensive care within the full continuum of patient needs. A higher proportion of patients are returned to function within the community.

(5) Frequent transfers to acute care with the resultant personal trauma and excessive cost can be avoided when a GNP is consistently available to monitor and manage care.

We solicit your assistance in addressing these issues for the benefit of our older, frail citizens and the integrity of our long-term care health providers.

Sincerely,

PRISCILLA EBERSOLE,
Field Director.

Appendix 3

STATEMENTS SUBMITTED BY THE HEARING AUDIENCE

During the course of the hearing, a form was made available by the committee to those attending who wished to make suggestions and recommendations but were unable to testify because of time limitations. The form read as follows:

DEAR SENATOR BURDICK: If there had been time for everyone to speak at the hearing on "Health Care for the Elderly: What's in the Future for Long-Term Care?" in Bismarck, N. Dak., on April 6, 1982, I would have said:

The following replies were received:

JUDY BICKLE, BISMARCK, N. DAK.

At the hearing on April 6, 1982, there was a great deal of discussion about the high cost of nursing homes.

I feel it would be important to take a look at the cost of private home nursing agencies also. It is my understanding that the cost of having 7 hours of home nursing care would be equivalent to 24 hours in a skilled nursing facility. In my estimation, this is no bargain.

If there are to be more care services available to the elderly, there must be some way of keeping costs reasonable for those on fixed incomes otherwise it will be useless.

PAMELA A. BYRON, BISMARCK, N. DAK.

I have witnessed the changes that occur when a private nursing home (religiously affiliated) is sold to a for-profit organization. I had worked as a nurses aide from April 28, 1979 to October 1, 1980, for a private church-sponsored nursing home. Beginning October 1, 1980, this facility was then sold to a for-profit organization out of California. Although I only worked every other weekend, I couldn't believe how rapidly the quality of care decreased. We were allowed only so many workers per residents. Because of lack of staff and new policies and procedures, things really went to hell. The most visible changes were staffing and food services. I remember the kitchen placing dishes of butter (freshly cut without a cover) on the center of the tables and leaving them sit there all day. I also witnessed several residents placing their fingers in the butter. I remember how all the food was taken out of the storage room and used and never replaced. I finally quit February 15, 1981. Within that same time period about 8 to 10 other staff members quit. No one really knew what to do other than to quit.

MR. AND MRS. DAVE CRIMMINS, BISMARCK, N. DAK.

Keep the costs of insurance down. Include more optical and dental coverage. Provide for more trained home health care and provide more reliable home help care for the elderly. Why have prescription drug prices risen over 900 percent. I think this is outrageous! Major supplemental medical does not cover you after age 65. We need more coverage here.

KAREN DECKERT, BISMARCK, N. DAK.

Why are we, as a Nation so advanced in every other aspect, not placing our sights on "prevention"? I have an idea that it is merely due to lack of foresight. Our Nation has been so geared toward caring for the sick, that we have failed to recognize the well.

This concept brings to mind an episode that occurred during the polio crisis years. Many people were so busy building thousands of iron lungs, that no one paid any attention to developing a prevention except for one man, Jonas Salk, whom we all know developed the Salk vaccine.

Isn't it time that we, the people, demand a better system for educating our people on prevention?

As a Public Health nurse, I know that our concerns have always been in this area. We are facing dark days ahead in this fight, because it is very difficult to measure or document prevention. How I ask, except through future generations, can we put a dollar amount on prevention.

I urge you to take time to clearly sort out the many funding capabilities of our Nation, and weigh their merit.

Let's put our sights on prevention, not on sickness.

OLIVER (OLLIE) HVINDEN, BISMARCK, N. DAK.

(1) I agree that we must find alternatives to the use of nursing homes with the exorbitant costs assessed against the elderly during the remaining years of their life. These would include home health care, homemaker services, guest homes for the ones that do not need complete nursing care.

(2) We must find some way to provide the essential services needed for individual senior citizens with strict evaluation procedures as to what is necessarily needed and compensation to the service providers on an equitable basis whether private or public welfare patient.

(3) I am of the firm belief that we need to enact national legislation for health care services for all Americans. This would include health insurance similar to Senate bill 1720 and H.R. 5191 introduced in 1979. Call it socialized medical practice if you will but let the private individual share some of the cost too.

(4) Service providers and the medical associations are having a hey-day becoming fat-cats submitting fraudulent claims for services that a lot of patients don't even know about.

Thanks for letting me let off steam here. It wouldn't have been very appropriate at the hearing. Thanks also for coming here and listening to those that did testify.

Thanks to you and your staff for appearing here in Bismarck at our senior center.

Sorry to be so late with this but have been hospitalized for a period for an ailment that has been bothering for some time. Needless to say I had the very finest of care. Thanks to a dedicated staff of doctors, surgeons and nursing personnel.

GRACE S. LEE, BISMARCK, N. DAK.

I would like to see the home nursing and home care program funded more. This program would help to keep elderly and sick persons out of nursing homes. I have appreciated all the efforts you have made to help North Dakota citizens with their various problems.

LAURIE LYNCH, FARGO, N. DAK.

I support your proposed income tax credit for people caring for the elderly at home.

Another option for long-term care of the elderly should be adult day care. The Ebenezer Society in Minneapolis offers this service. The elderly who need assistance with their activities of daily living stay at the center during the day and return home to their families at night.

It was quite clear at the hearing that nurses are needed to give the quality nursing that is deserved by our elderly. In order to cut costs, nursing home administrators substitute untrained nurses aides to do patient care and even administer medications in place of "higher" paid nurses. This type of staffing is unsafe for nursing home settings. The administrators need to insure that staff is qualified to do these jobs.

Continue to support increased home health care and psychiatric service benefits for the elderly.

OLIVE J. MCPHERSON, BISMARCK, N. DAK.

In some areas, I believe it's too little, too late, and now with the big cut in most all of the good programs, this causes a lot of stress and mental anguish. Some of these poor older folks do not know which way to turn. It is frightening. Cost-of-living is out of sight and our social security isn't enough any more. I cannot understand why Reagan cut funds for the Green Thumb program. That was a bad mistake.

Home care is the best for everyone, no matter who, if it is possible and good outside service care is available.

ANNO VAN OOSTING, HENSLER, N. DAK.

I feel that the Government or someone has to take and do something to stop the double and triple charges that doctors and maybe hospitals charge and so write it up on bills so it is hard to spot.

I am contesting charges with one group on a recent hospital stay. I went in on October 29, 1981, and was out on November 19, 1981, and was charged for 22 days but I really was there only 21 as I got there about 7 p.m. and went out the last day without dinner at about 11 a.m. The total charges were $4,029.

On my doctor bill it gave charges as for one day $14 a call $42 for that day and the only time I saw them was once some days and maybe two times other days but most times they would not stay long enough to hear what you had to say.

Thanks.

ALICE R. SLAATEN, BISMARCK, N. DAK.

Help! I am asking this for all the neglected, unfortunate elderly who are locked into facilities unfit for animals. It's time we spend some money on searching out the pitfalls of these so called homes. They are literally prisons for many.

Why are we so short on money for human needs? We can spend billions over the allotted budget for the space program and can't meet the needs of our people. People, who sacrificed much to make this country of ours one of the best. Where are our priorities?

When we fail to recognize the needs of the aging, the poor, and the crippled—yes, and even our children, there is a real need for a change in who we send to Washington.

Let's start looking at these needs with love and a Christian compassion instead of the political "how many votes will this program bring?" The elderly have been and are being stripped of their lifetime savings, forcing them to the dreaded welfare programs, thus taking away the only thing they have left—their pride.

Inflation is not the reason this program is so neglected. Spending is! We stop at nothing when we budget for arms and weapons to kill people. Let's put our spending priorities where they belong. Please spend to protect us from the poverty, loss of pride and cruelty that exists in the present programs for the aging.

This is not just an opinion with no foundation as to its validity. I speak with authority, having had my father fall victim to what I've just talked about, for 5 years while he was ill and needed skilled care. I saw so much agony, loneliness, and abuse I could write a book on it. This took place in the U.S.A. in facilities our country provides for its elderly and the sick. I'm not at all proud of the programs we now have and I know we have the means for a better job.

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